

Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Wednesday, August 14, 2013 at the hour of 8:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

**I. Attendance/Call to Order**

Chairman Collens called the meeting to order.

Present: Chairman Lewis M. Collens and Directors Wayne M. Lerner and Luis Muñoz, MD, MPH (3)  
Director Ada Mary Gugenheim

Absent: None (0)

Additional attendees and/or presenters were:

Krishna Das, MD – System Director of Quality, Patient Safety, Regulatory and Accreditation  
Aaron Hamb, MD – Provident Hospital of Cook County  
Randolph Johnston – System Associate General Counsel  
Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer

Deborah Santana – Secretary to the Board  
John Jay Shannon, MD – Chief of Clinical Integration  
Ozuru Ukoha, MD – John H. Stroger, Jr. Hospital of Cook County  
Pierre Wakim, MD – Provident Hospital of Cook County

**II. Public Speakers**

Chairman Collens asked the Secretary to call upon the registered speakers.

The Secretary called upon the following public speaker:

1. George Blakemore Concerned Citizen

**III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation (Attachment #1)**

Dr. Krishna Das, System Director of Quality, Patient Safety, Regulatory and Accreditation, presented her report, which included information on the following subjects: overview of regulations guiding hospital quality efforts; updated survey information; and overview of publicly reported metrics. The Committee reviewed and discussed the information.

Chairman Collens inquired regarding the aggregate rate of 72% of 107 patients under the measure of Initial Antibiotic Selection for CAP in Immunocompetent Patient, which was reflected in the Hospital Compare Report - Fourth Quarter 2011 through Third Quarter 2012 Discharges (included in Attachment #1). Dr. Das responded that this is a question on antibiotic selection. This is one of the more controversial guidelines provided by the Centers for Medicare and Medicaid Services (CMS). CMS has been criticized because, especially several years ago, not every guideline was entirely evidence-based; CMS is very actively in the process of revising these guidelines. The antibiotic guideline is one of those guidelines where they recommend sort of a “one size fits all” antibiotic treatment regimen for all patients with pneumonia. Upon review of the System’s internal data, it was found that these regimens are perhaps not optimal for the System’s patients; staff tries to base antibiotic therapy based on the local disease prevalence and the antibiotic sensitivities.

### **III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation (continued)**

Director Lerner noted that, as the System moves more toward managing a population's health, it needs to move more away from an inpatient orientation towards measuring and monitoring quality, to something that's much broader than that; under the leadership of Dr. Ram Raju, Chief Executive Officer, the Committee should take some time to talk about that at a future time.

Earlier in the meeting, Director Gugenheim had inquired regarding the definition of "patient-centered"; the response had been that patient-centered care involves treating the patient with respect and incorporating the patient into the decision-making process with respect to their care. Director Lerner stated that, nowadays, health systems are including humanity and kindness in their definition of patient-centered care; this is not typically what one would think about when they think about patient-centered improvements, so how the System builds the humanity and kindness into its measures is critical. Additionally, he stated that none of these measures engage the individual, and the individual's responsibility for their own care, or what he likes to call the co-obligation - the obligation of the individual to the System, and the System to the individual. As the System moves toward managing the population, there needs to be thought given to something different, in terms of outcome.

### **IV. Action Items**

#### **A. Minutes of the Quality and Patient Safety Committee Meeting, July 10, 2013**

Director Lerner, seconded by Director Muñoz, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of July 10, 2013. THE MOTION CARRIED UNANIMOUSLY.

#### **B. \*\*Medical Staff Appointments/Re-appointments/Changes (Attachment #2)**

Director Lerner, seconded by Director Muñoz, moved to approve the Medical Staff Appointments/Reappointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

#### **C. Any items listed under Sections IV, V and VI**

#### **D. Proposed revisions to the Bylaws of the Medical Staff of Provident Hospital of Cook County (Attachment #3)**

Dr. Pierre Wakim, President of the Executive Medical Staff (EMS) of Provident Hospital of Cook County, presented the item for the Committee's consideration, and provided an overview of the proposed revisions. Dr. Aaron Hamb, Medical Director of Provident Hospital of Cook County, provided additional information.

Director Lerner expressed concerns with the proposed revisions to Section 12.01.B., regarding voting by proxy. He stated that he was uncomfortable with allowing a proxy vote when someone is not present to vote themselves. This proposed change allows for an accumulation of proxy votes by a single individual or single group, and they could vote a bloc. He indicated that he was sure the intent for this proposed revision was in the event that an individual has an untoward event and they want to have their voice heard; however, this revision does not say that the individual votes, and then that vote is cast by someone else - this revision says that the individual is going to have someone vote their proxy. If this had been written as simply allowing another member to cast a written vote on behalf of the active member, he would not have had as much of an issue; under that scenario, the individual is not giving away their right to vote to someone else.

#### **IV. Action Items**

##### **D. Proposed revisions to the Bylaws of the Medical Staff of Provident Hospital of Cook County (continued)**

Dr. Wakim stated that this issue surfaced during the elections of officers; many of the physicians were on duty in the evenings in clinics and were unable to vote. He indicated that the intent was to have the proxy vote cast in the active member's wishes.

Following discussion, the Committee determined that a motion to approve the proposed revisions, with the exception of the revision proposed in Section 12.01.B. regarding proxy votes, would be in order. Chairman Collens added that there are provisions that are typically included in corporate bylaws that provide for unanimous written consent on certain key issues, which is the direction that he believed Director Lerner was discussing; he recommended that Dr. Wakim also consider this, when drafting proposed revisions to the Bylaws regarding voting by proxy.

Director Lerner, seconded by Director Muñoz, moved to approve the proposed revisions to the Bylaws of the Medical Staff of Provident Hospital of Cook County, with the exception of the revision proposed in Section 12.01.B. regarding voting by proxy. THE MOTION CARRIED UNANIMOUSLY.

#### **V. Recommendations, Discussion/Information Items**

##### **A. Discussion of 2013 Meeting schedule and planning for schedule of 2014 Committee Meetings**

Following discussion, the Committee determined that the schedule of remaining 2013 Quality and Patient Safety Committee Meetings does not require any adjustments at this time.

With regard to planning for the schedule of 2014 Committee Meetings, the consensus reached by the Committee indicated that they were in favor of holding the Committee Meetings and Board Meeting on the same day.

##### **B. Reports from the Medical Staff Executive Committees**

###### **i. Provident Hospital of Cook County**

###### **ii. John H. Stroger, Jr. Hospital of Cook County**

Dr. Wakim presented his report from the EMS of Provident Hospital of Cook County. He stated that the EMS met last Friday. There were discussions held regarding outpatient services that are provided at Provident Hospital, and regarding physician accountability - the ways and manners for all of the physicians to make sure that they are responsible and accountable for their County time. The Bylaws and proposed revisions that were presented today were discussed. There was a discussion regarding about the Bud Billiken Parade, which took place on August 10<sup>th</sup>. Dr. Wakim added that the 20<sup>th</sup> Anniversary of Provident Hospital will soon take place; he anticipates that it will be celebrated in December.

Dr. Ozuru Ukoha, President of the EMS of Stroger Hospital of Cook County, stated that the EMS did not recently meet; therefore, he had no report to present at this time.

**VI. Closed Session Items**

- A. \*\*Medical Staff Appointments/Re-appointments/Changes**
- B. Litigation Matter(s)**

The Committee did not recess the regular session and convene in closed session.

**VII. Adjourn**

As the agenda was exhausted, Chairman Collens declared that the meeting was  
ADJOURNED.

Respectfully submitted,  
Quality and Patient Safety Committee of the  
Board of Directors of the  
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX  
Lewis M. Collens, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX  
Deborah Santana, Secretary

Cook County Health and Hospitals System  
Quality and Patient Safety Committee Meeting Minutes  
August 14, 2013

ATTACHMENT #1

# Quality and Regulatory Overview

Board Quality and Patient Safety Meeting

CCHHS Board of Directors

14 August 2013

# Topics covered today

1. Overview of regulations guiding hospital quality efforts
2. Updated survey information
3. Overview of publicly reported metrics

# Definition of Quality

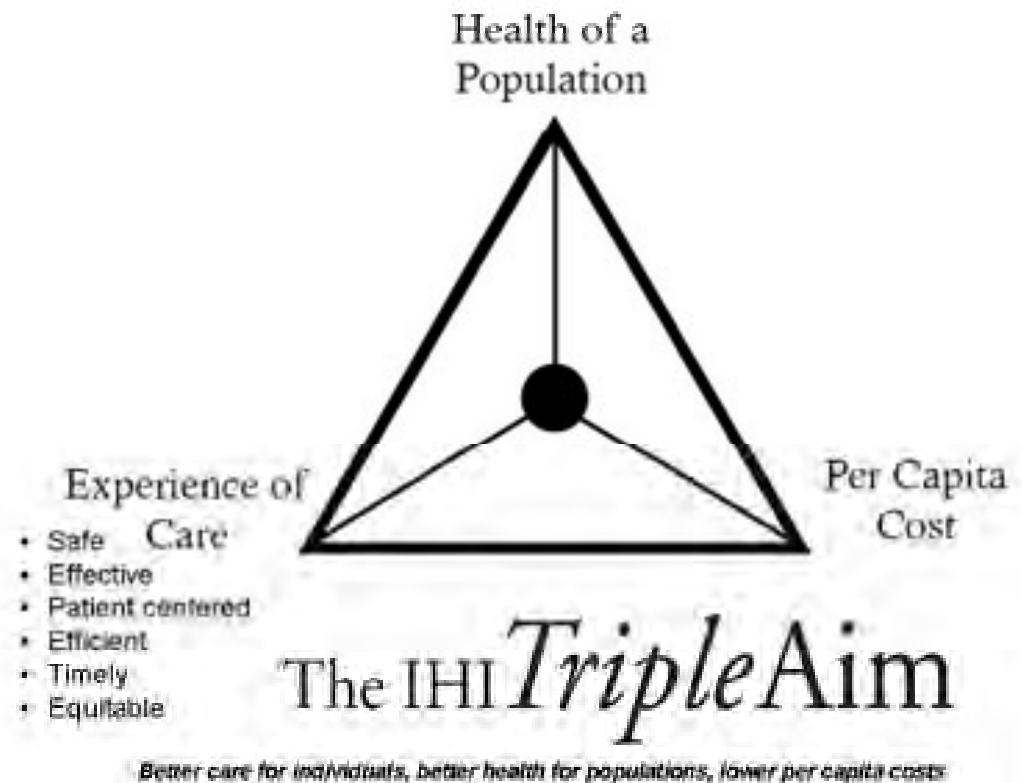
The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge

– *IOM, Crossing the Quality Chasm, 2002*



# IOM Six Aims of Improvement

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient Centered



# Evolution of Hospital Quality Programs

QA

QA/CQI

QPS/PI

# Regulatory Influences

- ACA (Affordable Care Act) – concept of quality improvement encoded into ACA – National Quality Strategy
- CMS (Centers for Medicare and Medicaid Services) – conditions of participation in Medicare, enunciated in a series of federal regulations; hospital cannot receive Medicare reimbursement if these are not met
- TJC (The Joint Commission) – accredits organizations and has ‘deemed status’ to certify that a hospital meets CMS conditions of participation (CoP)

# ACA Section 3011: National Strategy

## PART S—HEALTH CARE QUALITY PROGRAMS

### Subpart I—National Strategy for Quality Improvement in Health Care

#### SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

##### (a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

##### (2) IDENTIFICATION OF PRIORITIES.—

(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

- (i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;
- (ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;
- (iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;
- (iv) improve Federal payment policy to emphasize quality and efficiency;
- (v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

# CMS Regulations

## Centers for Medicare & Medicaid Service

### § 482.12 Condition of participation: Governing body.

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

(a) *Standard: Medical staff.* The governing body must:

(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;

(3) Assure that the medical staff has bylaws;

(4) Approve medical staff bylaws and other medical staff rules and regulations;

(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;



# CMS Regulations

## Subpart C—Basic Hospital Functions

### § 482.21 Condition of participation: Quality assessment and performance improvement program.

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

(a) *Standard: Program scope.* (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.

(2) The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

(i) Focus on high-risk, high-volume, or problem-prone areas;

(ii) Consider the incidence, prevalence, and severity of problems in those areas; and

(iii) Affect health outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

(d) *Standard: Performance improvement projects.* As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations.

(2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not

# Joint Commission Standards

## Leadership

- The governing board is ultimately accountable for the safety and quality of care, treatment and services
- Leaders create and maintain a culture of safety and quality throughout the hospital
- The hospital uses data and information to guide decisions and to understand variation in the performance of processes

# Joint Commission Standards

## Medical Staff

- The hospital has an organized medical staff that is accountable to the governing body
- The organized medical staff oversees the quality of care, treatment and services provided
- The governing body, senior managers and leaders of the organized medical staff regularly communicate with each other on issues of safety and quality



# Joint Commission Standards

## Performance Improvement

- The hospital collects data to monitor its performance
  - The leaders set priorities for data collection
  - The leaders identify the frequency of data collection
- The following data is collected:
  - Operative and other high risk procedures
  - Pathologic diagnoses
  - Significant medication errors
  - Blood transfusion reactions
  - Results of resuscitation
  - Patient perception of safety and quality of care

# IOM Six Aims of Improvement

## DEFINES FUNCTIONS OF A QUALITY DEPARTMENT

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient Centered
- Patient Safety
  - Retrospective
  - Prospective
- Process and outcome measures
  - Throughput, capacity management
  - ‘Core’ measures
- Patient satisfaction
- Performance improvement
- Regulatory compliance

# Regulatory Calendar

Regulatory Agency	Facility	Most Recent Survey	Next Expected Survey
Joint Commission	Stroger Hospital/ CORE Center	Nov 2012	Feb 2015-Nov 2015
	Ambulatory & Community Health Network	Apr 2011	Jul 2013-Apr2014
	Provident Hospital	Oct 2011	Jan 2014-Oct 2014
College of American Pathology	Laboratory System	Oct 2012	Aug 2014-Nov 2014
Department of Justice	Cermak Health Services	Apr 2013	Nov 2013 (every 6 months)
Illinois Dept of Public Health			As required
ACGME	Residency Training Programs	Various	Various

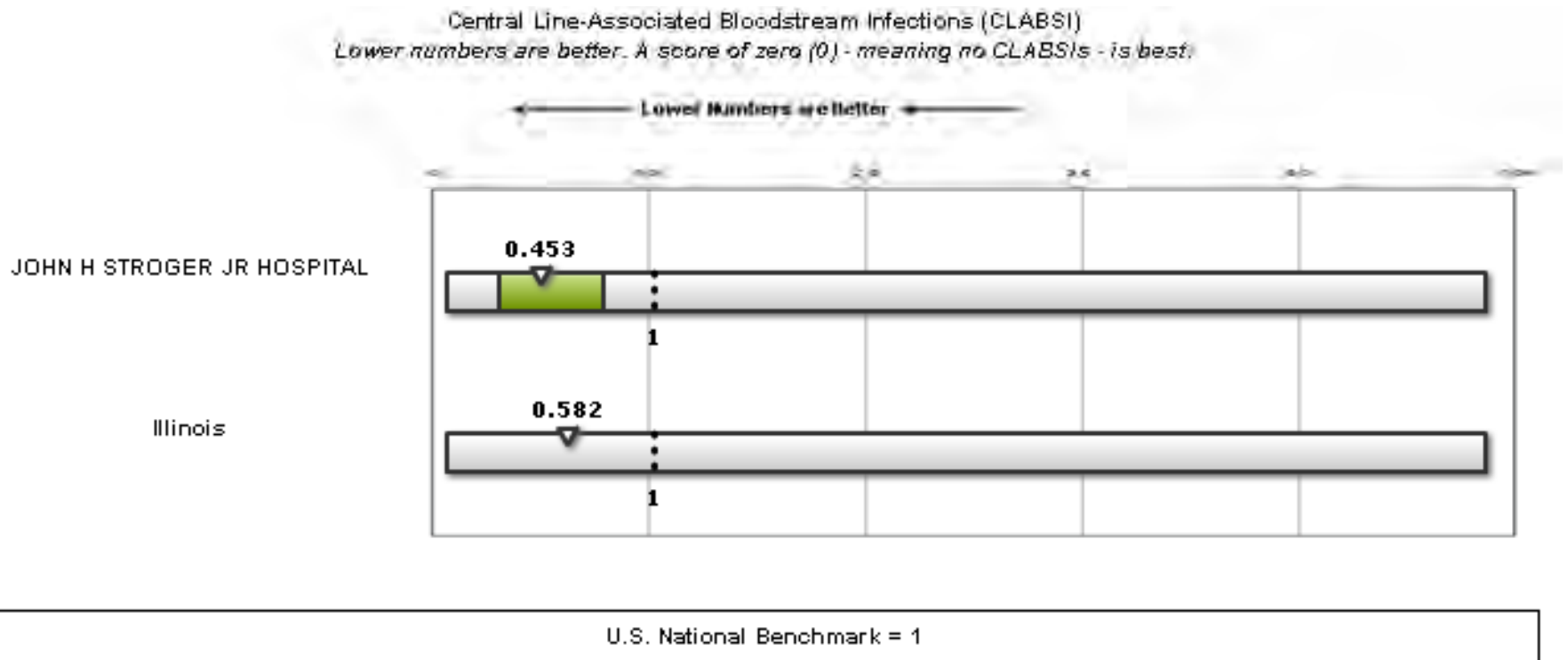
# Hospital Compare

## Public Reporting of Quality Data

- [www.medicare.gov/hospitalcompare/](http://www.medicare.gov/hospitalcompare/)
- Most data is abstracted from patient records
- Follows domains as outlined:
  - Safe – hospital acquired conditions
  - Timely, efficient – ED throughput measures
  - Effective – hospital quality measures ‘core’
  - Patient satisfaction – HCAHPS satisfaction survey
- Data lags by 9 - 12 months
- Details of currently available data – on handout

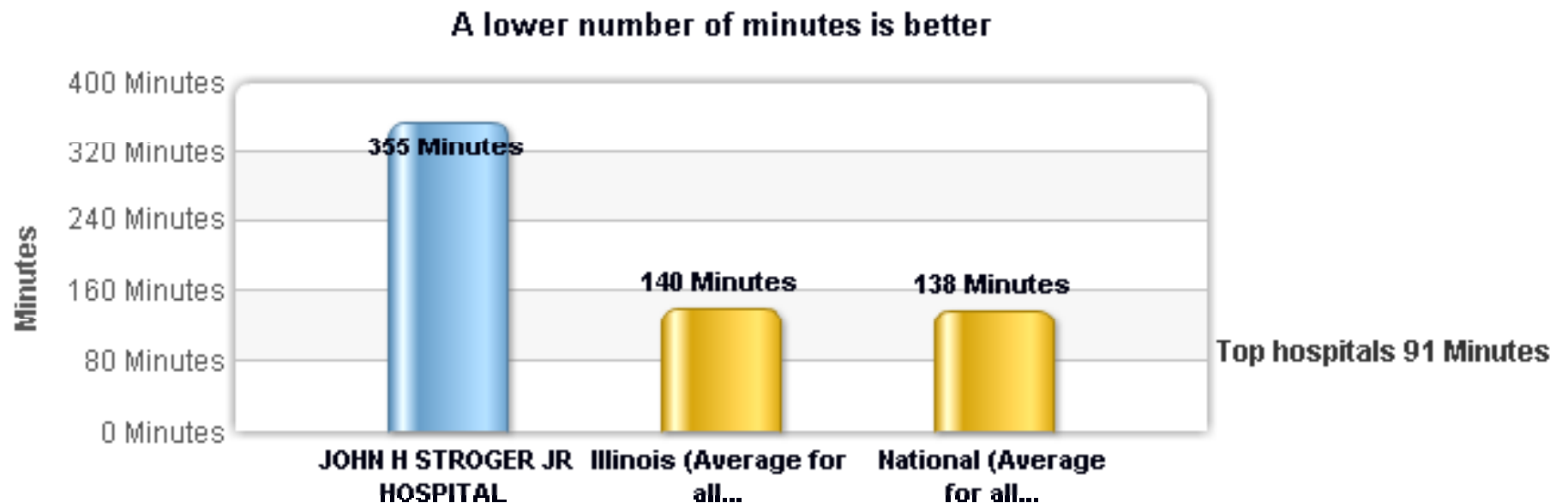
# Hospital Compare: Safe Care

## Central Line Associated Bloodstream Infections (CLABSI)



# Hospital Compare: Timely, Efficient

Time patients spent in the emergency department before being sent home

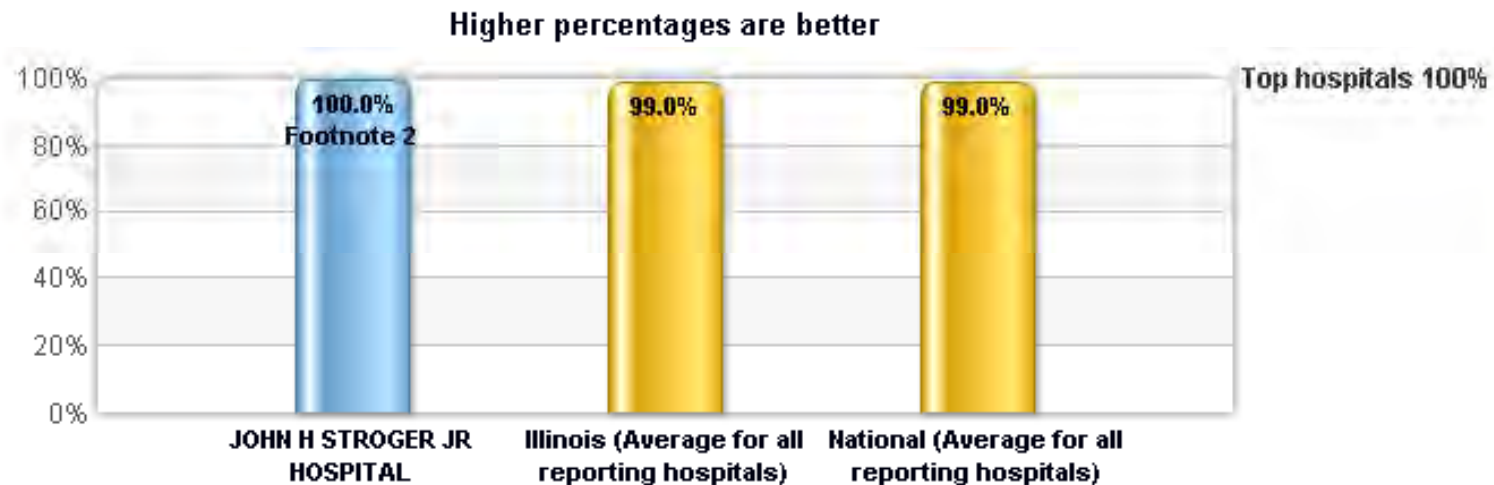


# Hospital Compare: EffectiveCare

Heart attack patients given aspirin at discharge

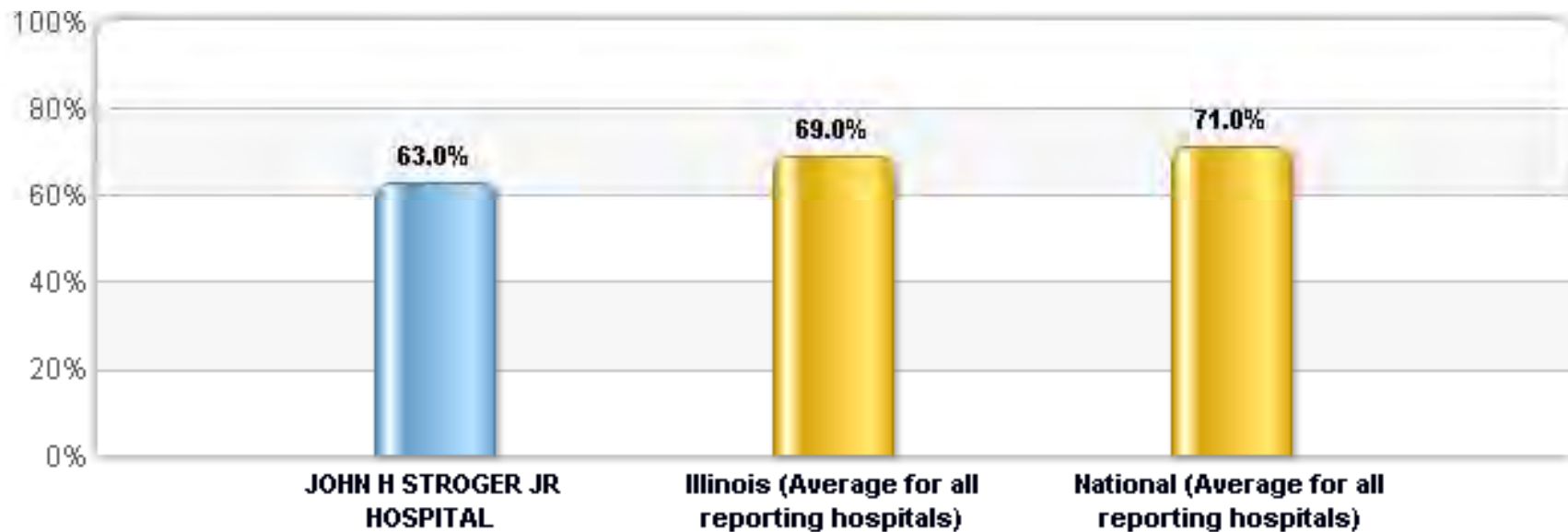
[Why is this important?](#)

[Hide Graph](#)



# Hospital Compare: Patient Centered

Patients who reported YES, would definitely recommend the hospital





# QUESTIONS?

Reporting Period for Clinical Process Measures: Fourth Quarter 2011 through Third Quarter 2012 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: First Quarter 2011 through Fourth Quarter 2011 All Paid Medicare FFS Claims

**140124-JOHN H STROGER JR HOSPITAL**

Address: 1901 W HARRISON ST  
 City, State, ZIP: CHICAGO, IL 60612  
 Phone Number: (312) 864-6000  
 County Name: COOK

Type of Facility: Short-term  
 Type of Ownership: Government - Local  
 Emergency Service Provided: Yes

OP-12	Does/did your facility have the ability to receive laboratory data electronically directly into your ONC certified EHR system as discrete searchable data?	Yes			
OP-17	Does your facility have the ability to track clinical results between visits?	Yes			
OP-22	Patient left before being seen	7735/30911 (25%)			
	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
<b>AMI Cardiac Care</b>					
OP-1	Median Time to Fibrinolysis	N/A(5)	20 Minutes	25 Minutes	28 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(5)	100%	70%	58%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention-Reporting Rate	N/A(5)	38 Minutes	61 Minutes	58 Minutes
OP-4	Aspirin at Arrival	N/A(5)	100%	96%	97%
OP-5	Median Time to ECG	N/A(5)	3 Minutes	6 Minutes	7 Minutes
<b>Surgical Care</b>					
OP-6	Timing of Antibiotic Prophylaxis	96% of 171 patients	100%	97%	97%
OP-7	Prophylactic Antibiotic Selection for Surgical Patients	86% of 169 patients	100%	97%	97%

Reporting Period for Clinical Process Measures: Fourth Quarter 2011 through Third Quarter 2012 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: First Quarter 2011 through Fourth Quarter 2011 All Paid Medicare FFS Claims

**140124-JOHN H STROGER JR HOSPITAL**

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
<b>Outpatient Imaging Efficiency (OIE)</b>					
OP-8	MRI Lumbar Spine for Low Back Pain	N/A(1)	N/A	36.0	36.5
OP-9	Mammography Follow-up Rates	N/A(1)	N/A	8.5	8.8
OP-10	Abdomen CT - Use of Contrast Material	14.3% of 546 scans	N/A	13.2	12.7
OP-11	Thorax CT - Use of Contrast Material	2.1% of 469 scans	N/A	3.9	3.7
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	2.0% of 98 patients	N/A	5.6	5.5
OP-14	Simultaneous use of brain Computed Tomography (CT) and sinus Computed Tomography (CT)	N/A(1)	N/A	2.7	2.8
<b>Emergency Department</b>					
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	355 Minutes based on 524 patients	91 Minutes	140 Minutes	138 Minutes
OP-20	Median Time from ED Arrival to Provider Contact for ED patients	170 Minutes based on 483 patients	14 Minutes	31 Minutes	28 Minutes
OP-21	Median Time to Pain Management for Long Bone Fracture	169 Minutes based on 254 patients	37 Minutes	54 Minutes	60 Minutes
<b>Stroke</b>					
OP-23	Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	N/A(5)	100%	56%	46%

**Footnote Legend**

\*OP-1 Measure data displayed on the preview report will be available through the download process and excluded from display on Hospital Compare.

**0 patients: No patients met the criteria for inclusion in the measure calculation.**

1. The number of cases is too small to reliably tell how well a hospital is performing.
3. Rate reflects fewer than maximum possible quarters of data.
4. Suppressed for one or more quarters by CMS.
5. No data are available for publication from the hospital for this measure.

## Hospital Performance

Reporting Period for Clinical Process Measures: Fourth Quarter 2011 through Third Quarter 2012 Discharges

**140124-JOHN H STROGER JR HOSPITAL**

Address: 1901 W HARRISON ST  
 City, State, ZIP: CHICAGO, IL 60612  
 Phone Number: (312) 864-6000  
 County Name: COOK

Type of Facility: Short-term  
 Type of Ownership: Government - Local  
 Emergency Service Provided: Yes

Participation in a Systematic Database for:  
 Cardiac Surgery: Does Not Have a Program  
 Stroke Care: No  
 Nursing Sensitive Care: No

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
<b>Acute Myocardial Infarction (AMI)</b>					
AMI-2	Aspirin Prescribed at Discharge	100% of 258 patients(2)	100%	99%	99%
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0 patients(2)	100%	50%	61%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	92% of 13 patients(1,2)	100%	96%	95%
AMI-10	Statin Prescribed at Discharge	96% of 262 patients(2)	100%	98%	98%
<b>Heart Failure (HF)</b>					
HF-1	Discharge Instructions	89% of 282 patients(2)	100%	95%	93%
HF-2	Evaluation of LVS Function	99% of 287 patients(2)	100%	99%	99%
HF-3	ACEI or ARB for LVSD	99% of 144 patients(2)	100%	97%	97%
<b>Pneumonia (PN)</b>					
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	95% of 125 patients(2)	100%	98%	97%
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	72% of 107 patients(2)	100%	94%	95%
<b>Surgical Care Improvement Project (SCIP)</b>					
SCIP-Inf-1	Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	97% of 285 patients(2)	100%	99%	98%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	96% of 282 patients(2)	100%	99%	99%

## Hospital Performance

Reporting Period for Clinical Process Measures: Fourth Quarter 2011 through Third Quarter 2012 Discharges

## 140124-JOHN H STROGER JR HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
<b>Surgical Care Improvement Project (SCIP)</b>					
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	97% of 275 patients(2)	100%	98%	97%
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose	88% of 120 patients(2)	100%	96%	96%
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	97% of 151 patients(2)	100%	96%	96%
SCIP-Inf-10	Surgery Patients with Perioperative Temperature Management	100% of 289 patients(2)	100%	100%	100%
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	98% of 122 patients(2)	100%	97%	97%
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	97% of 222 patients(2)	100%	98%	98%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	97% of 222 patients(2)	100%	98%	98%
<b>Emergency Department</b>					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	639 Minutes based on 904 patients(2)	175 Minutes	260 Minutes	274 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	261 Minutes based on 903 patients(2)	42 Minutes	90 Minutes	96 Minutes
<b>Immunization Measures</b>					
IMM-1a	Pneumococcal Immunization	38% of 549 patients(2)	98%	90%	88%
IMM-2	Influenza Immunization	65% of 306 patients(2)	98%	88%	86%

## Footnote Legend

0 patients: No patients met the criteria for inclusion in the measure calculation.

1. The number of cases is too small to reliably tell how well a hospital is performing.
2. Measure reflects the hospital's indication that its submission was based upon a sample of its relevant discharges.
3. Rate reflects fewer than maximum possible quarters of data.
4. Suppressed for one or more quarters by CMS.
5. No data are available for publication from the hospital for this measure.

## Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Fourth Quarter 2011 through Third Quarter 2012 Discharges

**140124-JOHN H STROGER JR HOSPITAL**

Address: 1901 W HARRISON ST  
 City, State, ZIP: CHICAGO, IL 60612  
 Phone Number: (312) 864-6000  
 County Name: COOK

Type of Facility: Short-term  
 Type of Ownership: Government - Local  
 Emergency Service Provided: Yes

Participation in a Systematic Database for:  
 Cardiac Surgery: Does Not Have a Program  
 Stroke Care: No  
 Nursing Sensitive Care: No

**HCAHPS Survey Completion and Response Rate**

**Number of Completed Surveys** 1288

**Survey Response Rate** 16

**HCAHPS Composites and Individual Items**

		Your Hospital's Adjusted Score			State Average			U.S. Average		
HCAHPS Composites		% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	11	21	68	5	17	78	5	17	78
Composite 2 (Q5 to Q7)	Communication with Doctors	5	13	82	4	15	81	4	15	81
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	22	26	52	10	25	65	9	24	67
Composite 4 (Q13 & Q14)	Pain Management	11	22	67	7	23	70	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	25	18	57	20	18	62	19	18	63
Hospital Environment Items		% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	21	25	54	9	18	73	9	18	73
Q9	Quietness of Hospital Environment	18	28	54	11	30	59	10	30	60
Discharge Information Composite		% Yes		% No	% Yes		% No	% Yes		% No
Composite 6 (Q19 & Q20)	Discharge Information	79		21	84		16	84		16

## Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Fourth Quarter 2011 through Third Quarter 2012 Discharges

## 140124-JOHN H STROGER JR HOSPITAL

## HCAHPS Global Items

		Your Hospital's Adjusted Score			State Average			U.S. Average		
Q21	Overall Rating of Hospital	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating
Overall Rating of Hospital (0 = Worst Hospital 10 = Best Hospital)		15	30	55	9	23	68	8	22	70
		Your Hospital's Adjusted Score			State Average			U.S. Average		
Q22	Willingness to Recommend this Hospital	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend
Willingness to Recommend this Hospital		7	30	63	5	26	69	5	24	71

## Footnote Legend

6. Fewer than 100 patients completed the HCAHPS survey. Use these rates with caution, as the number of surveys may be too low to reliably assess hospital performance.
7. Survey results are based on less than 12 months of data.
8. Survey results are not available for this reporting period.
9. No or very few patients were eligible for the HCAHPS survey.
11. There were discrepancies in the data collection process.
12. Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.

## Hospital Performance

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Mortality, Readmission, and Complication Outcome Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

**140124-JOHN H STROGER JR HOSPITAL**

Address: 1901 W HARRISON ST  
 City, State, ZIP: CHICAGO, IL 60612  
 Phone Number: (312) 864-6000  
 County Name: COOK

Type of Facility: Short-term  
 Type of Ownership: Government - Local  
 Emergency Service Provided: Yes

Participation in a Systematic Database for:  
 Cardiac Surgery: Does Not Have a Program  
 Stroke Care: No  
 Nursing Sensitive Care: No

**30-Day Risk-Standardized Mortality Measures**

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small*
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	No Different than U.S. National Rate	57	14.8% (11.0%, 19.3%)	15.2%		in the <b>Nation</b> that Performed ...	77	2579	19	1889
							in the <b>State</b> that Performed ...	8	112	0	61
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No Different than U.S. National Rate	141	10.4% (7.4%, 14.6%)	11.7%		in the <b>Nation</b> that Performed ...	181	3732	139	725
							in the <b>State</b> that Performed ...	16	156	5	7
Pneumonia (PN)											
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	No Different than U.S. National Rate	63	10.8% (7.3%, 15.8%)	11.9%		in the <b>Nation</b> that Performed ...	203	4014	223	377
							in the <b>State</b> that Performed ...	16	157	7	4



## Hospital Performance

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Mortality, Readmission, and Complication Outcome Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

## 140124-JOHN H STROGER JR HOSPITAL

## 30-Day Risk-Standardized Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small*
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	No Different than U.S. National Rate	62	19.8% (15.9%, 24.4%)	18.3%		in the <b>Nation</b> that Performed ...	22	2333	24	2085
							in the <b>State</b> that Performed ...	0	103	5	71
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	No Different than U.S. National Rate	185	25.5% (21.2%, 30.2%)	23.0%		in the <b>Nation</b> that Performed ...	105	3904	146	631
							in the <b>State</b> that Performed ...	0	169	10	5
Pneumonia (PN)											
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	No Different than U.S. National Rate	76	18.7% (14.8%, 23.2%)	17.6%		in the <b>Nation</b> that Performed ...	25	4331	101	376
							in the <b>State</b> that Performed ...	0	172	8	5

## Hospital Performance

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Mortality, Readmission, and Complication Outcome Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

**140124-JOHN H STROGER JR HOSPITAL****30-Day Risk-Standardized Readmission Measures**

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small*
Hip/Knee											
READM-30-HIP-KNEE	30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	N/A(5)	N/A(5)	N/A(5)	5.4%		in the <b>Nation</b> that Performed ...	50	2740	37	665
							in the <b>State</b> that Performed ...	1	110	4	24
Hospital-Wide											
READM-30-HOSPWIDE	30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	Worse than U.S. National Rate	1114	17.8% (16.1%, 19.1%)	16.0%		in the <b>Nation</b> that Performed ...	304	3983	364	158
							in the <b>State</b> that Performed ...	3	139	36	1

## Hospital Performance

Reporting Period for 30-Day Hospital-Wide Outcome Measures: Third Quarter 2011 through Second Quarter 2012 Discharges

Reporting Period for 30-Day Mortality, Readmission, and Complication Outcome Measures: Third Quarter 2009 through Second Quarter 2012 Discharges

## 140124-JOHN H STROGER JR HOSPITAL

## Risk-Standardized Complication Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Complication Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	U.S. National Rate		Number of Hospitals...	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	Number of Cases Too Small*
Surgical Complication											
COMP-HIP-KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	N/A(5)	N/A(5)	N/A(5)	3.4%		in the <b>Nation</b> that Performed ...	72	2658	68	687
							in the <b>State</b> that Performed ...	2	108	3	25

## Footnote Legend

\*The Number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing.

5. No data are available for publication from the hospital for this measure.

## Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2009 through Second Quarter 2011 Discharges

**140124-JOHN H STROGER JR HOSPITAL**

Address: 1901 W HARRISON ST  
 City, State, ZIP: CHICAGO, IL 60612  
 Phone Number: (312) 864-6000  
 County Name: COOK

Type of Facility: Short-term  
 Type of Ownership: Government - Local  
 Emergency Service Provided: Yes

Participation in a Systematic Database for:  
 Cardiac Surgery: Does Not Have a Program  
 Stroke Care: No  
 Nursing Sensitive Care: No

**AHRQ Measures - Patient Safety Indicators**

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	U.S. National Rate per 1,000		Number of Hospitals...	Better than U.S. National Rate / Value	No Different than U.S. National Rate / Value	Worse than U.S. National Rate / Value	Number of Cases Too Small*
Individual Patient Safety Indicators (PSIs)											
PSI-4	Death among surgical inpatients with serious treatable complications	No Different than U.S. National Rate	51	147.69 (103.14, 192.24)	113.43		in the <b>Nation</b> that Performed ...	63	1888	84	961
							in the <b>State</b> that Performed ...	10	87	1	26
Composite Patient Safety Indicator (PSI)											
PSI-90	Complication / patient safety for selected indicators (composite)	No Different than U.S. National Rate	N/A	N/A	N/A		in the <b>Nation</b> that Performed ...	156	3115	215	N/A
							in the <b>State</b> that Performed ...	6	118	9	N/A

## Hospital Performance

Reporting Period for Healthcare Associated Infection Measures: Fourth Quarter 2011 through Third Quarter 2012 Discharges

## 140124-JOHN H STROGER JR HOSPITAL

## Healthcare Associated Infection

Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device Days / Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio	U.S. National Standardized Infection Ratio
<b>Central Line Associated Bloodstream Infection (CLABSI)</b>							
Central Line Associated Bloodstream Infection	15	12518	33.084	0.453(0.254,0.748)	Better than the U.S. National Benchmark	0.582	0.554
<b>Catheter Associated Urinary Tract Infections (CAUTI)</b>							
Catheter Associated Urinary Tract Infections	34	7869	22.521	1.510(1.045,2.110)	Worse than the U.S. National Benchmark	1.103	1.092
<b>Surgical Site Infection (SSI)</b>							
SSI-Colon Surgery	2	156	5.558	0.360(0.044,1.300)	No different than the U.S. National Benchmark	0.668	0.811
SSI-Abdominal Hysterectomy	0	170	1.839	0.000(--,2.006)(22)	No different than the U.S. National Benchmark	0.933	0.991

## Footnote Legend

\*The Number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing.

3. Rate reflects fewer than maximum possible quarters of data.

5. No data are available for publication from the hospital for this measure.

14. No data are available for publication from the hospital for this measure because there were zero central line days.

15. No data are available for publication from the hospital for this measure because this hospital does not have ICU locations for one or more quarters.

22. The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.

Cook County Health and Hospitals System  
Quality and Patient Safety Committee Meeting Minutes  
August 14, 2013

ATTACHMENT #2

# John H. Stroger, Jr. Hospital of Cook County



## Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

### INITIAL APPOINTMENT APPLICATIONS

Abegundle, Ayokunle, T., MD Appointment Effective:	Medicine/Hospital Medicine August 14, 2013 thru August 13, 2015	Voluntary Physician
Auguston, Priscilla, A., MD Appointment Effective:	Family Medicine August 14, 2013 thru August 13, 2015	Active Physician
Balla, Leszek, DDS Appointment Effective:	Surgery/Oral Health August 14, 2013 thru August 13, 2014	Active Dentist
Couch, Clarissa, M., DDS Appointment Effective:	Surgery/Oral Health August 14, 2013 thru August 13, 2014	Active Dentist
Cull, John, D., MD Appointment Effective:	Surgery/General Surgery August 14, 2013 thru August 13, 2015	Voluntary Physician
Jung, Alan, J., MD Appointment Effective:	Medicine/Hospital Medicine August 14, 2013 thru August 13, 2015	Voluntary Physician
Koshy, Anoop, A., MD Appointment Effective:	Medicine/Endocrinology August 14, 2013 thru August 13, 2015	Active Physician
Lightfoot, Lori, DDS Appointment Effective:	Surgery/Oral Health August 14, 2013 thru August 13, 2014	Active Dentist
Punj, Shweta, MD Appointment Effective:	Medicine/Hospital Medicine August 14, 2013 thru August 13, 2015	Voluntary Physician
Sahni, Ashima Syngal, MD Appointment Effective:	Medicine/Hospital Medicine August 14, 2013 thru August 13, 2015	Voluntary Physician
Theobald, Jillian Lee, MD Appointment Effective:	Emergency Medicine August 14, 2013 thru August 13, 2015	Voluntary Physician
Thompson, Karen, DO Appointment Effective:	Surgery/Cardiac August 14, 2013 thru August 13, 2015	Voluntary Physician
Watts, Tabitha, MD Appointment Effective:	Pediatrics August 14, 2013 thru August 13, 2015	Voluntary Physician

### Initial Non-Physician Appointment Applications

Darby, Darchell D., PA-C With Linn, Edward S., MD Alternate Abrego, Fidel, MD Effective:	OB/GYN  August 14, 2013 thru August 13, 2015	Physician Assistant
Roberts, Kenrick L., PA-C With Keen, Richard R., MD Alternate Blumetti, Jennifer, MD Effective:	Surgery / Vascular Surgery  August 14, 2013 thru August 13, 2015	Physician Assistant

**CCHHS  
APPROVED**

**BY THE QUALITY AND PATIENT SAFETY COMMITTEE**

**ON AUGUST 14, 2013**

**REVISED**

**John H. Stroger, Jr. Hospital of Cook County**  
**Initial Non-Physician Appointment Applications (continued)**

Wright, LaDonna D., PA-C With Piette, Warren W., MD Alternate Clar, Steven A., MD Effective:	Medicine / Dermatology  August 14, 2013 thru August 13, 2015	Physician Assistant
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**REAPPOINTMENT APPLICATIONS**

**Department of Emergency Medicine**

Bishof, Christine, MD Reappointment Effective:	Emergency Medicine September 21, 2013 thru September 20, 2015	Service Physician
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**Department of Medicine**

Boddicker, Marc, E., MD Reappointment Effective:	Dermatology September 17, 2013 thru September 16, 2015	Consulting Physician
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Leeka, Deepak MD Reappointment Effective:	Internal Medicine/ACHN September 22, 2013 thru September 21, 2015	Active Physician
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Margeta, Bosko, MD Reappointment Effective:	Adult Cardiology September 7, 2013 thru September 6, 2015	Active Physician
--	--	------------------

Poku, Caroline, A., MD Reappointment Effective:	General Medicine September 22, 2013 thru September 21, 2015	Active Physician
--	--	------------------

Vernik, Jane, MD Reappointment Effective:	Nephrology & Hypertension September 26, 2013 thru September 25, 2015	Active Physician
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**Department of Obstetrics and Gynecology**

Sharma, Sameer, MD Reappointment Effective:	Oncology September 18, 2013 thru September 17, 2015	Active Physician
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**Department of Pediatrics**

Jain, Renu, MD Reappointment Effective:	Neonatology September 22, 2013 thru September 21, 2015	Consulting Physician
--	---	----------------------

Mayefsky, Jay Hirsh, MD Reappointment Effective:	ACHN September 15, 2013 thru September 14, 2015	Active Physician
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**Department of Surgery**

Godsel, Mark, DPM Reappointment Effective:	Podiatry September 28, 2013 thru September 27, 2015	Active Podiatrist
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Szatkowski, Jan Paul, MD Reappointment Effective:	Orthopaedics September 20, 2013 thru September 19, 2015	Active Physician
--	--	------------------


Szczerba, Stefan, MD Appointment Effective:	Plastic Surgery September 17, 2013 thru September 16, 2015	Active Physician
--	---	------------------

Thompson, Lisa, MD Appointment Effective:	Ophthalmology September 6, 2013 thru September 5, 2015	Consulting Physician
--	---	----------------------

Item IV(B) – August 14, 2013

CCHHS Quality and Patient Safety Committee Meeting

Page 2 of 5

  
**CCHHS**  
**APPROVED**  
 BY THE QUALITY AND PATIENT SAFETY COMMITTEE  
 ON AUGUST 14, 2013  
**REVISED**



## John H. Stroger, Jr. Hospital of Cook County(continued)


### Renewal of Privileges for Non-Medical Staff

Bonecutter, Bruce, PhD Effective:	Psychiatry/Psychology/Juvenile September 22, 2013 thru September 21, 2015	Clinical Psychologist
Conant, James, PsyD Effective:	Psychiatry/psychology/Juvenile September 22, 2013 thru September 21, 2015	Clinical Psychologist
Connolly, Colette B., CNS With Yu, Yan K., DO Effective:	Correctional Health Services August 14, 2013 thru August 13, 2015	Clinical Nurse Specialist
Duda, Jane E., CRNA Effective:	Anesthesiology / Pediatric October 16, 2013 thru October 15, 2015	Nurse Anesthetist
Lyons, Mary T., CNS With Severin, Paul N., MD Effective:	Pediatrics / Peds Critical Care October 16, 2013 thru October 15, 2015	Clinical Nurse Specialist
Santos, Kristine S., CNP With Martinez, Jaime, MD Effective:	Pediatrics / Adolescent Medicine August 26, 2013 thru August 25, 2015	Nurse Practitioner
Sit, Phyllis M., CRNA Effective:	Anesthesiology / Adult Anesthesia October 16, 2013 thru October 15, 2015	Nurse Anesthetist

### Medical Staff Status Change with no Change in Privileges

Erickson, Paul, MD	From: Active Physician	To: Voluntary Physician
Ray, Vera, MD	From: Consulting Physician	To: Voluntary Physician

**CCHHS**  
**APPROVED**  
**BY THE QUALITY AND PATIENT SAFETY COMMITTEE**  
**ON AUGUST 14, 2013**



# Provident Hospital of Cook County



## Medical Staff Reappointments and Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

### INITIAL APPOINTMENT APPLICATION

Ghode, Reena, MD	Internal Medicine	Affiliate Physician
Appointment Effective:	August 14, 2013 thru August 13, 2015	

### REAPPOINTMENT APPLICATIONS

#### Department of Clinical Labs/Anatomic Pathology

Strauss, Ronald, MD	Pathology	Affiliate Physician
Reappointment Effective:	September 20, 2013 thru September 19, 2015	

#### Department of Emergency Medicine

Ahmad, Wakas, DO	Emergency Medicine	Active Physician
Reappointment Effective:	September 22, 2013 thru September 21, 2015	

Hussain, Anwer, DO	Emergency Medicine	Active Physician
Reappointment Effective:	August 14, 2013 thru August 13, 2015	

Schaider, Jeffrey, MD	Emergency Medicine	Affiliate Physician
Reappointment Effective:	September 22, 2013 thru September 21, 2015	

<del>Sigamony, Ranjit, MD</del>	<del>Emergency Medicine</del>	<del>Active Physician</del>
<del>Reappointment Effective:</del>	<del>September 20, 2013 thru March 19, 2014</del>	

<del>Vaseemuddin, Mohammad, MD</del>	<del>Urgent Care Medicine</del>	<del>Active Physician</del>
<del>Reappointment Effective:</del>	<del>September 20, 2013 thru March 19, 2014</del>	

#### Department of Family Medicine

Daugherty, Milton, MD	Psychiatry	Consulting Physician
Reappointment Effective:	August 14, 2013 thru August 13, 2015	

Tinfang, Chantal, MD	Family Medicine	Active Physician
Reappointment Effective:	August 19, 2013 thru August 18, 2015	

#### Department of Internal Medicine

Fakhran, Sherene S., MD	Internal Medicine <u>Pulmonary Medicine</u>	Affiliate Physician
Reappointment Effective:	August 14, 2013 thru August 13, 2015	

Johnson, Claudia, MD	Gastroenterology	Consulting Physician
Reappointment Effective:	August 14, 2013 thru August 13, 2015	

Kelly, Michael A., MD	Internal Medicine	Affiliate Physician
Reappointment Effective:	September 7, 2013 thru September 6, 2015	

**CCHHS**  
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BY THE QUALITY AND PATIENT SAFETY COMMITTEE  
ON AUGUST 14, 2013



**Provident Hospital of Cook County**  
**Reappointment Applications (continued)**

**Department of Obstetrics and Gynecology**

Gandia, Justin Kidd, MD	Obstetrics/Gynecology	Active Physician
Reappointment Effective:	September 20, 2013 thru September 19, 2015	

**Department of Surgery**

Alsaden, Mahdi, MD	General Surgery	Active Physician
Reappointment Effective:	September 15, 2013 thru September 14, 2015	

Godsel, Mark, DPM	Podiatry	Affiliate Podiatrist
Reappointment Effective:	September 28, 2013 thru September 27, 2015	

<del>Szatkowski, Jan, MD</del>	<del>Orthopedics</del>	<del>Affiliate Physician</del>
<del>Reappointment Effective:</del>	<del>October 18, 2013 thru October 17, 2015</del>	


**Non-Medical Staff Privileges:**

El, Katherine, PA-C	Emergency Medicine	Physician Assistant
With Roskam, Stephen, DO		
Alternate Wakim, Pierre E., DO		
Effective:	September 20, 2013 thru September 19, 2015	

Powell, Stephanie P., PA-C	Internal Medicine / Int. Med.	Physician Assistant
With Charles, Lesley A., MD		
Alternate Moswin, Arthur H., MD		
Effective:	August 14, 2013 thru August 13, 2015	

**Medical Staff Status Change with no Change in Privileges**

Ray, Vera, MD	From: Consulting Physician	To: Voluntary Physician
---------------	----------------------------	-------------------------

  
**CCHHS**  
**APPROVED**  
**BY THE QUALITY AND PATIENT SAFETY COMMITTEE**  
**ON AUGUST 14, 2013**

Cook County Health and Hospitals System  
Quality and Patient Safety Committee Meeting Minutes  
August 14, 2013

ATTACHMENT #3

## **Bylaws Summary of Approved Changes**

Chief Medical Officer has been changed throughout the Bylaws to Medical Director

System Chief Medical Officer changed to Executive Medical Director throughout the Bylaws

### Section 4.04 – Procedure for Appointment

#### G - 4 Medical Executive Committee – Information Added

“...If the recommendation of the Medical Executive Committee is to deny the application for initial appointment, the ~~Chief Medical Officer~~ Medical Director shall notify the Applicant, in writing, that the Medical Executive Committee has recommended that his or her application for initial appointment ~~has been~~ denied. Such notice shall be sent as provided in Section 19.04 (b), Special Notice.”

#### G – 6 Cook County Health and Hospitals System Board – Change reflects

“...If the Board approves the application for initial appointment and clinical privileges, the ~~Chief Medical Officer~~ CVO shall notify the Applicant of his or her appointment.”

### Section 4.06 Procedure for Reappointment

#### F – Cook County Health and Hospitals System Board – Change reflects

“...In arriving at its determination, the Board may seek additional information from the various Departments and committees which have considered the application. If the Board grants the application for reappointment, the ~~Chief Medical Officer~~ CVO shall notify the Member of his or her reappointment.”

### Article 7: Hearing Procedures

#### 7.05 – Notification of Adverse Action – Change reflects

“(d) inform the Member that a hearing must be requested within ~~fifteen~~ thirty (~~15~~ 30) days from receipt of such notice;

#### 7.09 – Notice of Hearing – Change reflects

“If a Member requests a hearing within the ~~fifteen~~ thirty (~~15~~ 30) day period ....”

### Article 12: Medical Staff Meetings

#### 12.01 – Medical Staff Meetings

##### B – Regular Meetings – Information Added

“A Member who is entitled to vote on any matter at such meeting may, in writing presented to the Secretary, permit a Member who is also entitled to vote, to vote on her or his behalf on a matter that has been included in the meeting notice required by Section 12.02, Notice.”

#### 14.08 – Joint Conference Committee

##### A – Composition – Change reflects

“The Joint Conference Committee shall consist of not less than three (3) members of the Cook County Health and Hospitals System Board as appointed by its Chairman; an equal number of representatives of the Medical Staff ~~who shall consist of~~ from among the Officers of the Medical Staff and ~~up to two~~ the Department Chairperson(s) who shall be appointed by the President of the Medical Staff to serve terms of this Committee...”

# BYLAWS OF THE MEDICAL STAFF OF PROVIDENT HOSPITAL OF COOK COUNTY

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# **BYLAWS OF THE MEDICAL STAFF OF PROVIDENT HOSPITAL OF COOK COUNTY**

## **PREAMBLE**

**WHEREAS**, Provident Hospital of Cook County (hereinafter "Hospital") is a public hospital organized under the laws of the State of Illinois; and

**WHEREAS**, the Hospital's mission is to provide quality comprehensive health care services to all of Cook County's residents, regardless of ability to pay, through both the direct delivery of services and through the establishment of collaborative relationships with other public and private health care providers; and,

**WHEREAS**, the Hospital's mission is also to provide health care to all patients regardless of the actual or perceived status, practice or expression of the patient's race, color, religion, age, sex, disability, ancestry, sexual orientation, marital status, parental status, military discharge status, source of income, gender identity, ability to pay or national origin, and to offer unique education, training and research opportunities; and

**WHEREAS**, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and accepts and discharges this responsibility subject to the ultimate authority of the Cook County Health and Hospitals System Board of Directors and that the cooperative efforts of the Medical Staff, the Chief Operating Officer, the Chief Executive Officer of the Cook County Health and Hospitals System, and the Cook County Health and Hospitals System Board of Directors are necessary to fulfill the Hospital's obligations to its patients;

**THEREFORE**, the physicians, podiatrists and dentists practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

## **ARTICLE 1: DEFINITIONS**

**Applicant** shall mean a physician, dentist or podiatrist who has submitted a completed application for initial appointment to the Medical Staff.

**Cook County Health and Hospitals System Board or Board** shall mean the Cook County Health and Hospitals System Board of Directors, which is the governing body of the Hospital.

**System or Cook County Health and Hospitals System (CCHHS)** shall mean the Cook County Health and Hospitals System, the System established by Cook County Ordinance to consolidate the various health care facilities owned and operated by the County of Cook, including Provident Hospital of Cook County.

**Category** shall mean one of the Categories set forth in Article 5 Categories of the Medical Staff.

**Chief Operating Officer** shall mean the Chief Operating Officer of Provident Hospital of Cook County and shall include his or her designee.

**Clinical Privileges** shall mean the permission granted to provide medical or other patient care services and permission to use hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical or other patient care services at this Hospital.

**Collaborative Clinical Privileges or Collaborative Privileges** shall mean permission granted a Mid-Level Practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services at Hospital in accordance with Supervision Document.

**CVO** shall mean the Cook County Health and Hospitals System Credentialing Verification Office and, where applicable, the Hospital's Credentials Verification Office.

**Dentist** shall mean an individual who is licensed to practice dentistry in the State of Illinois and shall include oral surgeon.

**Department** shall mean the largest class of Hospital medical service unit; usually a primary medical specialty.

**Ex-Officio** shall mean by reason of administrative office; shall have no vote unless otherwise specified in these Bylaws.

**Hospital** shall mean Provident Hospital of Cook County.

**Hospital Administration** shall mean the Chief Operating Officer and all other persons delegated administrative duties by the Chief Operating Officer.

**Hospital Representative** shall mean the Board, its committees and members, the CCHHS Chief Executive Officer, the Chief Operating Officer, the ~~Chief Medical Officer~~ [Medical Director](#), and all Medical Staff committees, Members and other staff of the Hospital or the System who have responsibility for collecting or evaluating an Applicant's or Member's credentials or acting upon his or her application for appointment or reappointment.

**IDFPR** shall mean Illinois Department of Financial and Professional Regulation.

**Licensed Independent Practitioner** shall mean a health professional, other than a physician, dentist or podiatrist who is licensed by the State of Illinois and is granted Clinical Privileges to provide care to Hospital patients.

**Member** shall mean a Member doctor of medicine (M.D.), osteopathy (D.O.), dentistry (D.D.S. or D.M.D) or podiatry (D.P.M.) duly licensed in Illinois who has been appointed to the Medical Staff.

**Medical Staff or OMS** shall mean the Organized Medical Staff of Provident Hospital of Cook County which shall comprise all Illinois licensed physicians, dentists and podiatrists who have been appointed to the Medical Staff.

**Membership** shall mean the appointment of a physician, dentist or podiatrist to the Medical Staff including the Clinical Privileges, if any, granted with that appointment.

**Mid-Level Practitioner** shall mean an Advanced Practice Nurse or a Physician Assistant who is granted Collaborative Clinical Privileges.

**National Practitioner Data Bank** shall mean the data bank established pursuant to Section 421 of the Health Care Quality Improvement Act, 42 United States Code 11101, et seq., to which medical malpractice payments, sanctions by the Boards of Medical Examiners, and Professional Review Actions relative to members of the Medical Staff are reported.

**Non-Member Practitioner** shall mean licensed professionals who are granted either Clinical Privileges or Collaborative Clinical Privileges to provide direct or indirect patient care to Hospital patients, including Mid Level Practitioners (MLPs) and Licensed Independent Practitioners (LIP). Non-Member Practitioners are not members of the Medical Staff.

**Physician** shall mean an individual who is licensed to practice medicine in all its branches in the State of Illinois.

**Podiatrist** shall mean an individual who is licensed to practice podiatry in the State of Illinois.

**President** shall mean President of the Medical Staff.

**Rules and Regulations** shall mean the policies and procedures adopted by the

Medical Staff to establish a framework for self-governance of Medical Staff activity and accountability to the Governing Body.

**Supervision Document** shall mean a Collaborative Agreement or other document which has been approved by the System Mid-Level Practitioner Committee and which, subject to the Medical Staff's approval of Collaborative Privileges, establishes the permitted scope of practice of a Mid-Level Practitioner in collaboration with a Member.

**Telemedicine** shall mean the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

## **ARTICLE 2: NAME**

### **2.01 NAME**

The name of this Medical Staff shall be the "Medical Staff of Provident Hospital of Cook County".

## **ARTICLE 3: PURPOSES**

### **3.01 PURPOSES**

The purposes of the Medical Staff shall be:

To promote the provision of appropriate and ethical care to all inpatients and outpatients treated at the Hospital consistent with acceptable medical standards;

To promote and maintain an appropriate level of professional standards consistent with community standards through the continuous review and evaluation of the clinical activities of the Medical Staff and the delineation of privileges to practice within the Hospital;

To promote the continuing education of all members of the Medical Staff, to maintain educational standards for the Medical Staff and to provide educational opportunities for House Staff and other medical professionals in training;

To initiate and maintain Rules and Regulations for the governance of the Medical Staff;

To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Cook County Health and Hospitals System Board, the Chief Executive Officer of the Cook County Health and Hospitals System, and the Chief Operating Officer in an effort to resolve any problems; and

To provide leadership in the Hospital in quality and performance improvement activities.

## **ARTICLE 4: MEDICAL STAFF MEMBERSHIP AND PRIVILEGES**

### **4.01 MEMBERSHIP**

Membership on the Medical Staff of the Hospital is a privilege which shall only be extended to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and the corporate Bylaws of the Hospital. No individual shall be entitled to membership on the Medical Staff or the granting of clinical privileges merely by virtue of the fact that he or she is duly licensed to practice his or

her profession in this or any other state, or that he or she is a member of some professional organization, or that he or she had, in the past, or presently has such privileges at other this or any other hospital or health care facility. In determining whether or not to extend or continue the privilege of Membership, neither the Board nor any of Hospital Committee shall discriminate against any Applicant or Member on the basis of the actual or perceived status, practice or expression of the their race, color, religion, age, sex, disability, ancestry, sexual orientation, marital status, parental status, military discharge status, gender identity, or national origin. Membership of the Hospital is a privilege in the nature of a license to exercise only those clinical privileges within the Hospital as are specifically granted in accordance with the procedures established in these Bylaws.

#### **4.02 ELIGIBILITY FOR MEMBERSHIP: QUALIFICATIONS AND STANDARDS**

To be eligible for consideration for appointment or reappointment to membership on the Medical Staff, Applicants or Members must demonstrate and continue to meet the following qualifications and standards to assure that any patient treated by them will be given quality medical care:

(a)Licensure to practice medicine in all its branches in the State of Illinois, licensure to practice dentistry in the State of Illinois, or licensure to practice podiatric medicine in the State of Illinois, as well as a State of Illinois Controlled Substance Certificate and Controlled Substance Registration Certificate (Federal Drug Enforcement Administration [DEA]), where appropriate;

(b) Ability to work professionally and constructively with other members of the Medical Staff and Hospital personnel;

(c)Education, training, experience, ability and current competence in the field of practice;

(d) Adequate skills to maintain effective communication with members of the Medical Staff and Hospital Personnel;

(e)Satisfactory health such that the member may perform the essential functions required by the member's delineated clinical privileges with appropriate judgment and technical skill, either with or without an accommodation;

(f)Commitment to participate in the purposes, functions and duties of the Medical Staff;

(g) Adherence to the ethics of their profession and their good reputation; and,

(h) Qualifications sufficient to merit a faculty appointment at an academic institution with which the Hospital is affiliated.

It shall be the continuing obligation of every Applicant for initial appointment to the Medical Staff and of every Member to notify the ~~Chief Medical Officer~~[Medical Director](#) immediately of any action which is taken by any authority in any state which restricts, conditions, modifies or terminates the Applicant or Member's professional license, authority to prescribe controlled substances, eligibility to participate in state or federal programs or which involves conviction of a felony. Failure to provide such notification shall be grounds for summary suspension and termination from the Medical Staff.

#### **4.03 CONDITIONS OF APPOINTMENT/REAPPOINTMENT**

In accepting appointment or reappointment to the Medical Staff, each Member agrees to:



- (a) Comply with the principles of the relevant professional organizations;
- (b) Abide by the Medical Staff Bylaws and Rules and Regulations and the Hospital's
- (c) Provide continuous care to and supervision of his or her patients in the Hospital within the recognized professional level of quality and efficiency within the medical
- (d) Prepare and complete all medical records in a timely and legible manner and in accordance with these Bylaws and Rules and Regulations, i.e., a complete admission history and physical examination shall be completed and recorded no more than 30 days prior to, or within 24 hours after, a registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia by a physician, or other qualified licensed practitioner consistent with state law and hospital policy. This report should include all pertinent findings resulting from an assessment of systems of the body. It must also include the admitting diagnosis and diagnostic and therapeutic plans at a minimum. For a medical history and physical that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition must be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.
- (e) Carry out the duties and responsibilities required by the Category of Membership and the Department to which he or she has been assigned and accept and fulfill committee assignments;
- (f) Delegate the responsibility for diagnosis or care of hospitalized patients only to those practitioners who are qualified to undertake the responsibility;
- (g) Engage in patterns of appropriate utilization and allocation of resources with the goal of providing quality patient care in conformity with applicable utilization standards as may be defined from time to time by the Medical Staff and by the Cook County Health and Hospitals System Board as well as by applicable statutes and regulations, and participate in the Hospital's utilization review process, including service on the Utilization Review Committee of the Medical Staff as requested; and
- (h) Limit the scope of his or her practice at the Hospital in accordance with the Clinical Privileges granted to him or her.
- (i) The timely payment of dues and other fees as required by the Medical Executive Committee.

#### **4.04 PROCEDURES FOR APPOINTMENT**

##### **A. Appointment Authority and Term**

Initial appointments and reappointments to the Medical Staff shall be made by the Cook County Health and Hospitals System Board or its Quality and Patient Safety Committee in accordance with the appointment procedure set forth herein or in Section 4.07, Expedited Appointment and Re-appointment. The Cook County Health and Hospitals System Board or its Quality and Patient Safety Committee shall act on appointments and reappointments after there have been reviews and recommendations from the various committees, as provided in this appointment procedure; provided that, in the event of unwarranted delay on the part of any of the various committees, the Board may act without such recommendation on the basis of documented evidence of the Applicant's or Member's professional and ethical qualifications obtained from reliable sources.

Each initial appointment shall be provisional for a period of six (6) months. The Medical Executive Committee may extend this provisional period not to exceed an additional six (6) months upon the recommendation of the applicable Department Chair and the Credentials Committee unless terminated during his or her provisional period. The provisional appointment

period shall be for observation purposes which may include, but shall not be limited to, retrospective chart review and clinical supervision as per the Focused Professional Practice Evaluation plan approved by the relevant department. The purpose of the observation period is to judge the quality of patient care the Member delivers and the overall professional conduct of the Member.

As a condition of appointment during the provisional period, the Member shall agree that the appropriate Department Chairperson or an attending physician designated by him or her shall be empowered to assume responsibility for a patient whenever, in the sole judgment of the designated attending physician or the Chairperson, such action appears necessary to safeguard the patient's health or well-being.

As a further condition of appointment during the provisional period, the Member shall agree that he or she shall have no cause to complain or any cause of action in law or equity against a Chairperson or his or her designee who acts in good faith and without malice, or against the Hospital, the Medical Staff or any component or agent thereof acting in good faith and without malice to monitor the performance of the Member.

If a Member's Membership is terminated prior to the completion of his or her provisional period, the ~~Chief Medical Officer~~Medical Director shall notify him or her, in writing, that his or her Membership has been terminated and that he or she is entitled to a hearing pursuant to Article 7. Such notice shall be as provided in Section 19.04 (b), Special Notice.

If the Member is elevated to full appointment, the ~~Chief Medical Officer~~Medical Director shall notify him or her, in writing, of such elevation. The period of the initial full appointment following the provisional period shall not exceed two years less the period during which the Member was in the provisional period. Excluding this initial appointment period, each term of reappointment shall be for a period of two years.

### **B. Request for Application**

Requests for an application for initial appointment shall be in writing, addressed to the CVO and shall contain the name, address, and medical specialty of the Applicant. Upon receipt of such request, a letter will be sent to the individual outlining the criteria for an initial appointment, explaining the review process and enclosing a pre-application questionnaire. The individual will be requested to complete the pre-application questionnaire and return it to the CVO. If, after review of the pre-application questionnaire, it is determined that the Applicant fails to meet the criteria for an initial appointment, fails to meet the criteria for the privileges sought or has indicated that he or she is seeking assignment to a Department, subspecialty or Category for which there is no opening, the CVO shall notify the requestor that he or she will not be receiving an application and the reasons therefore. In those instances in which an application for initial appointment is sent, a copy of the Medical Staff Bylaws and Rules and Regulations shall be enclosed.

All applications for initial appointment to the Medical Staff shall be submitted on the forms prescribed by the Hospital and Medical Staff.

### **C. Content of Application**

Pursuant to the Illinois Health Care Professional Credentials Data Collection Act, 410 ILCS 517, each Applicant for initial appointment to the Medical Staff shall complete the Health Care Professional Credentialing and Business Data Gathering Form as provided by the Illinois Department of Public Health (IDPH Credentialing Form) in its entirety. The Applicant must also complete the Health Status Form, the CCHHS Credential Verification Supplemental Information form, and the Attestation and Release form and submit these, together with the IDPH

Credentialing Form, to the CVO. In addition to completing and submitting the foregoing, the Applicant shall complete and submit any other forms required by the Medical Staff to process the application.

#### **D. Return of Application**

The application for initial appointment shall be returned to CVO.

#### **E. Effect of Application**

By applying for initial appointment to the Medical Staff, the Applicant:

(1) Thereby signifies a willingness to appear for interviews in regard to the application, authorizes the Hospital to consult with others who have been associated with the Applicant or who may have information bearing on his or her competence and qualifications, and consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his or her qualifications for an initial appointment to the Medical Staff and to exercise the clinical privileges requested;

(2) Agrees to release from liability all the Hospital Representatives from all acts performed in connection with the evaluation, documentation, and investigation of the Applicant, in making recommendations with respect to his or her application for initial appointment, and further agrees to release from liability all individuals and organizations who provide information to the Hospital concerning the Applicant's qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information;

(3) Authorizes individuals and organizations to release information, including otherwise confidential or privileged information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital Representative, and consents to the procurement and inspection by any Hospital Representative of such information, records and other documents;

(4) Agrees to provide requested information regarding all prior professional liability insurance coverage and claims and to cooperate with the Hospital's verification of this information;

(5) Acknowledges that, upon receipt of the application, a request for information regarding the Applicant shall be submitted by the Hospital to the IDFPR, the National Practitioner Data Bank and other appropriate organizations which verify information regarding the Applicant;

(6) Acknowledges that falsification, withholding or material omissions of information, whenever discovered, may result in rejection of an initial application for Appointment or be grounds for disciplinary action, including revocation of clinical privileges and Medical Staff membership;

(7) Pledges to provide quality care for his or her patients if granted staff appointment and clinical privileges; and

(8) Agrees to sign a statement which acknowledges that he or she is fully informed of the scope and extent of the authorizations, releases and consent provisions stated above and that he or she is fully informed of, and agrees to be bound by, the immunity provisions contained in these Bylaws.

## **F. Review of Information**

When the application for initial appointment is returned to the CVO, it shall be reviewed to be certain all questions are answered fully. The CVO shall confirm licensure, narcotic permits, National Practitioner Data Bank information and verify references, and the information contained therein, as appropriate. The Applicant shall have the burden of producing adequate information or sources of information for the proper evaluation of his or her qualifications for appointment to the Medical Staff and the exercise of clinical privileges and for resolving any doubts about such qualifications. This shall include recommendations from peers in the same professional discipline concerning the applicant, to include information regarding the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism.

The application shall be not considered complete until (i) all blanks on the application form are filled in and any requested additional information has been provided; (ii) verification of the information is complete; (iii) information has been obtained from the National Practitioner Data Bank; and the IDFP and (iv) responsive letters of reference and information from past hospital and other affiliations have been received.

## **G. Processing the Application**

Each complete application for initial appointment shall be processed as expeditiously as practicable in accordance with the procedures set forth herein. After the application for initial appointment has been determined to be complete the application shall be processed in the following manner:

### **(1) Department Chairperson**

The complete application for initial appointment shall be forwarded by the CVO to the Department Chairperson for the Department to which the Applicant is requesting assignment. The Department Chairperson shall review the application. The Department Chairperson or his or her designee may conduct an interview of the Applicant. Within twenty-one (21) days after receipt of the application, the Chairperson of the Department shall forward his or her recommendation on the application for initial appointment and the granting of clinical privileges to the ~~Chief Medical Officer~~[Medical Director](#).

### **(2) ~~Chief Medical Officer~~[Medical Director](#)**

After receipt of the application for initial appointment and recommendations from the Department Chairperson, the ~~Chief Medical Officer~~[Medical Director](#) shall review the application. The ~~Chief Medical Officer~~[Medical Director](#) or his or her designee may conduct an interview of the Applicant. Within twenty-one (21) days after receipt of the application, the ~~Chief Medical Officer~~[Medical Director](#) shall forward to the Credentials Committee the application for initial appointment, his or her recommendation, and the recommendation of the Department Chairperson .

### **(3) Credentials Committee**

Within sixty (60) days of receipt of the application for initial appointment and recommendations from the Department Chairperson and the ~~Chief Medical Officer~~[Medical Director](#), the Credentials Committee shall review the application for initial

appointment and the recommendations. The Credentials Committee may conduct an interview of the Applicant. The Credentials Committee may defer action on an application for initial appointment in order to obtain needed additional information. Any such deferral shall state the reasons therefore, and shall set a time limit within which a subsequent recommendation to the Medical Executive Committee shall be made. The Credentials Committee shall then forward the application for initial appointment and the recommendations from the Department Chairperson and the ~~Chief Medical Officer~~Medical Director, as well as its own recommendation, on the prescribed form, to the Medical Executive Committee.

**(4) Medical Executive Committee**

At the next regular meeting of the Medical Executive Committee following receipt of the application for initial appointment and the recommendations from the Department Chairperson, ~~Chief Medical Officer~~Medical Director, and Credentials Committee, the Medical Executive Committee shall consider the application for initial appointment and recommendations and, if it wishes, interview the Applicant. The Medical Executive Committee may defer action on an application for initial appointment in order to obtain needed additional information. Any such deferral shall state the reasons therefore, shall set a time limit within which its recommendation to the Joint Conference Committee or to the Quality and Patient Safety Committee, as applicable, shall be made

If the recommendation of the Medical Executive Committee is to approve the application for initial appointment, it shall transmit its recommendation to the Joint Conference Committee, unless the application is eligible to be processed under Section 4.07, Expedited Appointment and Reappointment, in which case it shall transmit its recommendation to the Quality and Patient Safety Committee of the Board. If the recommendation of the Medical Executive Committee is to deny the application for initial appointment, the ~~Chief Medical Officer~~Medical Director shall notify the Applicant, in writing, that the Medical Executive Committee has recommended that his or her application for initial appointment ~~has been~~ denied. Such notice shall be sent as provided in Section 19.04 (b), Special Notice.

**(5) Joint Conference Committee**

At the next regular meeting of the Joint Conference Committee following receipt of the application for initial appointment and the recommendations from the Department Chairperson, ~~Chief Medical Officer~~Medical Director, Credentials Committee, and Medical Executive Committee, the Joint Conference Committee shall consider the application for initial appointment and recommendations and interview the Applicant, if it wishes. The Joint Conference Committee shall then make its recommendation to the Cook County Health and Hospitals Systems' Board.

If the recommendation of the Joint Conference Committee is to approve the application for initial appointment, the Chief Operating Officer shall transmit the recommendations to the Cook County Health and Hospitals Systems' Board.

If the Joint Conference Committee recommends that the application for initial appointment be denied, the ~~Chief Medical Officer~~Medical Director shall notify the Applicant, in writing, that his or her application for initial appointment has been denied. Such notice shall be sent as provided in Section 19.04 (b), Special Notice.

**(6) Cook County Health and Hospitals System Board**

At the next regularly scheduled meeting of the Cook County Health and Hospitals Systems' Board, or as soon thereafter as is practicable, the Board shall consider the recommendations on the application for initial appointment.

If the Joint Conference Committee recommended that the application for initial appointment be approved, the Board may, at its sole discretion, approve the application for initial appointment and the clinical privileges. Before arriving at its determination, the Board may seek additional information from those who have considered the application for initial appointment.

If the Board approves the application for initial appointment and clinical privileges, the ~~Chief Medical Officer~~ CVO shall notify the Applicant of his or her appointment. Such notice shall include:

- i) the Category to which the Applicant is appointed;
- ii) the Department to which he or she is assigned;
- iii) the Clinical Privileges he or she may exercise; and
- iv) any special conditions to the appointment.

If, after considering the recommendations, the Board denies the application for initial appointment, the Chief Operating Officer shall notify the Applicant in writing that his or her application for initial appointment has been denied. Such notice shall be sent as provided in Section 19.04 (b), Special Notice.

The fact that an Applicant has been found to be eligible for consideration by the Board shall not entitle the Applicant to membership. If the Quality and Patient Safety Committee acts on behalf of the Board on matters set forth in this paragraph (6), Cook County Health and Hospitals System Board, action on the application will not be deemed final until the Board has adopted the report of the Quality and Patient Safety Committee at the Board's next regular meeting.

#### **4.05 CLINICAL PRIVILEGES**

##### **A. Clinical Privileges**

In the course of developing his or her recommendation concerning an Applicant's application for initial appointment, the Department Chairperson shall consider the Applicant's requested Clinical Privileges and shall make a specific recommendation thereon which shall be included with his or her recommendation regarding the application for initial appointment. Each individual and committee evaluating the application for initial appointment shall consider the Department Chairperson's recommendation regarding the Applicant's requested Clinical Privileges and, if the individual and committee concur, include such clinical privilege recommendation in its recommendation regarding appointment to the Medical Staff. Should a committee not concur with the Department Chairperson's recommendation for Clinical Privileges, the request for Clinical Privileges may be returned to the Department Chairperson for further consideration in a timely manner as the remaining portions of the application continue through the appointment process.

Except for Emergency Privileges, a Member, shall exercise, only those Clinical Privileges specifically granted to him or her by the Cook County Health and Hospitals System Board in accordance with the Procedure set forth in these Bylaws.

## **B. Request for Change in Clinical Privileges**

A Member who desires a change in his or her clinical privileges shall make a written request for such a change with his or her application for reappointment or at any other time upon special written application.

If such a request is at the time of his or her application for reappointment, the request shall be considered pursuant to Article 4, Section 4.06, Procedures for Reappointment.

If such a request is not in conjunction with an application for reappointment, an evaluation of the requested change in Clinical Privileges shall be based on the Member's training, experience, and demonstrated competence and performance. All such requests shall be forwarded to the Department Chairperson for his or her consideration and recommendation and shall then be forwarded for consideration and recommendation in accordance with the procedures set forth in Article 4, Section 4.04, Procedures for Appointment.

If the Medical Executive Committee recommends that a Member's request for a change in clinical privileges be denied, the Member shall have the right to a hearing pursuant to Article 7, Hearing Procedures.

## **C. Temporary Privileges**

1. Temporary clinical privileges may be granted to an Illinois licensed physician, dentist or podiatrist to meet an important patient care need that requires immediate authorization to practice within the Hospital. Specifically, temporary clinical privileges may be granted for:

- the care of a specific patient(s);
- an individual serving as a *locum tenens* for a Member who is on vacation, attending an educational seminar, ill and/or needs coverage assistance for a period of time; or
- the purpose of proctoring, teaching or learning a new procedure at the Hospital.

### **2. Procedure**

a. The individual requesting temporary clinical privileges shall complete an application as set forth in Article 4, Section 4.04 (B), Request for Application, and forward it to the Credentialing Verification Office. Said application shall include a statement that, while practicing at the Hospital, the individual agrees to be bound by County, System, Hospital and Medical Staff policies and procedures and the Medical Staff Bylaws and Rules and Regulations.

b. After the Credentialing Verification Office has processed the application including a query of the IDFPR, and the NPDB, it shall forward the application to the Chief Operating Officer.

c. The Chief Operating Officer may grant temporary clinical privileges only with the approval of the applicable Department Chair, the ~~Chief Medical Officer~~[Medical Director](#) and the President.

d. If temporary clinical privileges are granted, they may be exercised only for a specific period of time as warranted by the situation. The grant of temporary clinical privileges should be for a period of time not exceeding 120 days.

e. If temporary clinical privileges are granted, the individual to who the privileges have



been granted shall act under the supervision of the applicable Department Chair or designee.

### **3. Termination**

a. The CCHHS Chief Executive Officer, Chief Operating Officer, ~~Chief Medical Officer~~Medical Director, Department Chair, or President may immediately terminate the temporary clinical privileges if the care or safety of patients might be endangered by continued treatment by the individual to whom they have been granted.

b. The granting of temporary clinical privileges is a courtesy and may be terminated at any time by the CCHHS Chief Executive Officer or Chief Operating Officer in consultation with the ~~Chief Medical Officer~~Medical Director, applicable Department Chair and President.

c. Unless terminated sooner, temporary clinical privileges shall automatically terminate upon expiration of the period for which they were granted.

d. Neither the denial nor termination of temporary clinical privileges shall entitle the individual to any of the procedural rights set forth in these Medical Staff Bylaws or Rules and Regulations.

e. An individual who has been granted temporary clinical privileges is not a Member of the Medical Staff, but shall comply with all applicable County, System, Hospital and Medical Staff rules, regulations and policies.

Temporary privileges may be granted for a period of no longer than 120 days and may not be extended.

### **D. Emergency Privileges**

Any Member may exceed the scope of his or her granted clinical privileges in any patient care emergency where time is of the essence in the preservation of life of a patient or the prevention of critical complications or serious harm and where an appropriately privileged Member is not immediately available to assume responsibility provided that the care, treatment and services provided are within the scope of his or her license. A Member who has exercised emergency privileges shall promptly report such use to both his Department Chair and the Chair of the Department in which such privileges are usually exercised, if applicable. In every case, the Member's Department Chair shall promptly evaluate the exercise of emergency privileges.

### **E. Disaster Privileges**

In the event of an emergency which results in the activation of the Hospital's emergency operations plan, the Chief Operating Officer or highest ranking administrator on site shall have the authority to grant disaster privileges to non-Members upon the recommendation of the President and ~~Chief Medical Officer~~Medical Director. Such privileges shall be memorialized on a disaster privileges form signed by the practitioner, the Chief Operating Officer or highest ranking administrator on site and by the President or ~~Chief Medical Officer~~Medical Director, or their designees, and shall be extended in accordance with regulations promulgated by the Illinois Department of Public Health which shall supersede any contrary provisions of this Section to the extent applicable.

### **1. System Physicians, Dentists and Podiatrists**



System physicians, dentists or podiatrists requesting disaster privileges shall present their System Affiliate photo identification to the Incident Commander or designee who shall verify the individual's current status against a list provided to the Incident Commander by the System's Credentials Verification Office.

**2. Non-System Physicians, Dentists and Podiatrists**

Non-System physicians, dentists or podiatrists requesting disaster privileges shall provide:

- (i) A currently valid Illinois license to practice medicine, dentistry or podiatry, out of state licensure will be accepted only if legally permissible due to the disaster; e.g., to a suspension of licensure requirements;
- (ii) Photo identification with the same name as that on their license to practice;
- (iii) A name of a hospital where they currently exercise clinical privileges, if any;
- (iv) The name of their professional liability insurance carrier, if any;
- (v) Their social security number and date of birth;
- (vi) Specialty training information; and
- (vii) All other necessary information required to conduct a query of the National Practitioner Data Bank and Illinois Department of Financial and Professional Regulation.

3. As soon as practicable, and if possible before granting disaster privileges, an attempt will be made to verify, through independent sources, licensure and other information available from the NPDB and IDFPR.

4. To the extent permitted by law and regulation and utilizing procedures consistent with those applicable to physicians, podiatrists or dentists granted disaster privileges, disaster privileges may also be granted to health professionals who are not physicians, podiatrists or dentists but who are licensed health professionals otherwise granted privileges or Collaborative Clinical Privileges pursuant to these Bylaws.

5. If possible, the practitioner granted privileges shall be assigned to a Member who is in the same specialty. The volunteer will act under the supervision of that Member. All disaster privileges shall terminate automatically once the Hospital Incident Command declares that the emergency is over.

**F. Lapse in Privileges: Interim Clinical Privileges**

No Member shall exercise Clinical Privileges unless such exercise occurs during the term of a grant of privileges pursuant to these Bylaws, including a grant of interim clinical privileges as provided herein. In the event of delay by the various committees to act promptly on an application for reappointment, the ~~Chief Medical Officer~~ [Medical Director](#) may grant interim Clinical Privileges for a period not to exceed sixty (60) days to a Member whose appointment and Clinical Privileges have expired pending action upon a Member's application for reappointment. Such interim privileges shall terminate immediately upon the approval or denial of the Member's application for reappointment. Approval of the application for reappointment shall be retroactive

to the date upon which a grant of interim Clinical Privileges was effective. Unless otherwise indicated in writing by the ~~Chief Medical Officer~~Medical Director, the Member granted interim Clinical Privileges shall be permitted to exercise the same Clinical Privileges and to occupy the same Category which was in effect at the time of the granting of interim Clinical Privileges. A Member who has been granted interim Clinical Privileges shall be bound by the provisions of these Bylaws.

## **G. Telemedicine**

1. The Medical Executive Committee shall recommend the scope of telemedicine services to be permitted at the Hospital. Requests for telemedicine privileges at the Hospital will be processed through the established procedure for reviewing and granting privileges as established elsewhere in these Bylaws.

Medical Staff members and/or Licensed Independent Practitioners (LIPs) who provide interpretive services such as official readings of images, tracings, or specimens (e.g., radiologists or pathologists) or consultations without directing patient care, through a telemedicine mechanism, must be privileged utilizing one of the following mechanisms:

- a. the Member or LIP may be fully credentialed and privileged at this Hospital or another System hospital;
- b. the Member or LIP is privileged at Hospital using credentialing information from a distant site entity that has an agreement with Hospital and meets the following criteria:
  - (i) the distant site is a hospital participating in Medicare or an entity that has a privileging and credentialing process that meets applicable TJC medical staff and governing body standards;
  - (ii) the Member or LIP must be privileged at the Distant Site for the services to be provided at Provident Hospital and the Distant Site provides a list of current privileges; and
  - (iii) Hospital collects and maintains evidence of an internal review of LIP's performance and sends to the Distant Site information that is useful to the Member's or LIP's quality of care, treatment and services for use in privileging and performance improvement including all adverse events resulting from telemedicine services and all complaints received about the Practitioner.
  - (iv) The Member or LIP holds a license issued or recognized by the State of Illinois

2. Members or LIPs granted privileges to provide telemedicine services at Provident Hospital will be governed by these Bylaws with the following exceptions:

- Call Coverage
- Meeting Attendance
- Dues

**A. Application for Reappointment**

Reappointments shall be made by the Board or its Quality and Patient Safety Committee in accordance with the appointment procedure set forth herein or in Section 4.07, Expedited Appointment and Re-appointment, for a period not to exceed two (2) years. The CVO shall, at least 120 days prior to the expiration date of the Member's current period of appointment, provide the Member with an application for reappointment. A Member who desires reappointment shall return the completed application for reappointment to the CVO at least 90 days prior to the date of expiration of his or her current period of appointment. A check made payable to the Medical Staff of Provident Hospital of Cook County must be submitted with the application for all applicable dues and fees.

The ~~Chief Medical Officer~~ Medical Director shall promptly give written notice to each Member who has failed to submit a timely application for reappointment. Upon receipt of the completed application for reappointment, the ~~Chief Medical Officer~~ Medical Director shall promptly notify the concerned Member of any deficiencies in his or her application for reappointment and the Member shall then have the obligation of providing the requested information. Failure, without good cause, to return the completed, signed application for reappointment at least thirty (30) days prior to the expiration of the Member's current period of appointment shall result in the automatic termination of Membership and clinical privileges at the expiration of the Member's current period of appointment as provided in Section 6.09 (a)(7) of these Bylaws.

Falsification, withholding or material omission of information, whenever discovered, may be grounds for corrective action, including termination of Membership and clinical privileges.

**B. Content of Form**

The form for applying for reappointment shall include the State of Illinois Application and the Reappointment Forms, (where appropriate, information required shall be limited to events occurring since the last date of appointment or reappointment):

(1) Pursuant to the Illinois Health Care Professional Credentials Data Collection Act, 410 ILCS 517, each Member who applies for reappointment to the Medical Staff shall complete the Health Care Professional Recredentialing and Business Data Gathering Form as provided by the Illinois Department of Public Health (IDPH Recredentialing Form) in its entirety. The Member must also complete the CCHHS Credential Verification Supplemental Information form, and the Attestation and Release form and submit these, together with the completed IDPH Recredentialing Form, to the Credentialing Verification Office. In addition to completing and submitting the foregoing, the Member shall complete and submit any other forms required by the Medical Staff to process the application for reappointment.

(2) A statement regarding the health status of the Member including information as to any health condition which would prevent the Applicant from performing the essential functions required in connection with the privileges sought and, if so, any a description of such reasonable accommodation which would enable the Applicant to perform those functions; and

(3) An acknowledgment that the Illinois Department of Professional Regulation and the

National Practitioner Data Bank will be contacted as part of the reappointment process.

### **C. Criteria for Reappointment to the Medical Staff**

Each recommendation concerning reappointment and continued clinical privileges of a Member shall be based upon such Member's:

(1) professional competency and clinical judgment in the treatment of patients based on Departmental and Hospital clinical evaluation and Quality and Performance Improvement information, Focused Professional Performance Evaluations and Ongoing Professional Performance Evaluations as well as recommendations from peers in the same professional discipline (to include medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism) when insufficient practitioner specific data is available;

(2) current clinical privileges and basis of any requested modification;

(3) attendance at applicable Medical Staff, Departmental and committee meetings and fulfillment of assigned responsibilities including responsibilities under any emergency patient care call schedule;

(4) compliance with the Hospital Policies and Procedures including County or System policies applicable to the Hospital, and with the Medical Staff Bylaws and Rules and Regulations;

(5) maintenance of an active role at the Hospital during the one year period preceding the application for reappointment, which shall refer to attendance at required medical staff and Departmental meetings and the provision of clinical patient care or clinical teaching duties during the preceding one year period;

(6) satisfactory completion of medical records;

(7) conduct, ethics, and behavior both in and out of the Hospital, cooperation with medical and Hospital personnel as it relates to patient care or the orderly operation of the Hospital, and general attitude toward patients, the Hospital and its personnel;

(8) information as to any health condition which prevents the Member from performing the essential functions required in connection with the privileges sought and a description of such reasonable accommodation which would enable the Applicant to perform those functions;

(9) documentation of continuing medical education; and evidence of continued competency;

(10) other matters bearing on the Member's ability and willingness to adhere to the standards of patient care generally accepted by the medical profession.

(11) appraisal of the individual provider by the Department Chair.

(12) evaluation from the Medical Director of the ambulatory site at which the member of the medical staff or non-member practitioner is assigned (if applicable).

### **D. Review of Application for Reappointment**

The review of a Member's application for reappointment will be based upon the information described in paragraph C., Criteria for Reappointment to the Medical Staff, above.

The applicable Department and various reviewing committees may request and the Member shall provide any further information or documentation considered necessary by the reviewing body to assess the application for reappointment and the continuation of or addition to privileges. The various reviewing bodies may take into consideration any and all information coming to their attention in arriving at their determinations. In performing their reviews, the various reviewing

bodies may call upon the Member for an interview. However, the Member shall not have a right to such an interview. There shall be no right of hearing and appeal regarding the findings and recommendations of either the initial review or the Credentials Committee.

### **E. Review of Information**

The Member shall submit the application for reappointment to the Hospital's Medical Affairs Office. The application shall not be considered complete until (i) all additional information has been provided; (ii) verification of the information is complete; (iii) information has been obtained from the National Practitioner Data Bank and the IDFPR; and (iv) information from Third Parties has been received.

Hospital Representatives will verify current medical licensure, narcotics permits, IDFPR and National Practitioner Data Bank information for each Member requesting reappointment. A Member's fully completed application for reappointment shall then be forwarded to the Department Chairperson for review and recommendation. If a Department Chairperson is the applicant for reappointment, the ~~Chief Medical Officer~~[Medical Director](#) shall conduct the initial review and make a recommendation.

After this initial review, the application and the initial reviewer's recommendation is forwarded to the Credentials Committee for review. The Credentials Committee shall review the application and recommendation and submit them, as well as its recommendation, to the Medical Executive Committee.

At the next regular meeting of the Medical Executive Committee following receipt of the application and recommendations, the Medical Executive Committee shall consider the application and recommendations. The Medical Executive Committee may defer action on an application in order to obtain needed additional information. Any such deferral shall state the reasons therefore, shall set a time limit in which a subsequent recommendation shall be made, and may include a directive as to what type of additional information is needed to clarify issues which are in doubt.

The Medical Executive Committee shall review the application and recommendations and shall vote upon its recommendation.

If the Medical Executive Committee recommends that the Member's application for reappointment and any increase in clinical privileges be granted, the Chief Operating Officer shall transmit the application and the findings and recommendations of the various Departments and committees which shall make its recommendation to the Quality and Patient Safety Committee of the Cook County Health and Hospitals System Board, if the Member qualifies under Section 4.07, Expedited Appointment and Reappointment, and to the Joint Conference Committee, if the Member does not qualify under Section 4.07. If the recommendation of the Medical Executive Committee is that the Member's application for reappointment should be denied, the ~~Chief Medical Officer~~[Medical Director](#) shall notify the Member, in writing, of this recommendation and the reasons therefore and inform the Member of the right to request, in writing, a hearing in accordance with Article 7 of these Bylaws within 30 days of receipt of the notice. Such notice shall be sent as provided in Section 19.04 (b), Special Notice.

For purposes of determining whether to request a hearing, the Member shall be on notice that this hearing and the post-hearing processes represent his or her opportunity to present relevant information related to that adverse recommendation and to appeal that adverse recommendation.

## **F. Cook County Health and Hospitals System Board**

With regard to applications that do not qualify for processing under Section 4.07, Expedited Initial Appointment and Reappointment, the findings and recommendations of the various committees and Departments shall be placed before the Board at its next regular meeting, for its review and consideration in determining whether or not to reappoint the Member. If the Quality and Patient Safety Committee acts on behalf of the Board on matters set forth in this paragraph F, Cook County Health and Hospitals System Board, action on the application will not be deemed final until the Board has adopted the report of the Quality and Patient Safety Committee at the Board's next regular meeting.

If the Joint Conference Committee, acting upon the recommendation of the Medical Executive Committee, recommends that the Member's application for reappointment and any requested increase in clinical privileges be granted, the Board may, at its sole discretion, extend such reappointment and any increase in clinical privileges which have been recommended. In arriving at its determination, the Board may seek additional information from the various Departments and committees which have considered the application. If the Board grants the application for reappointment, the ~~Chief Medical Officer~~CVO shall notify the Member of his or her reappointment. Such notice shall include:

- (1) the staff category to which the Member is reappointed;
- (2) the Department and division to which he or she is reappointed;
- (3) the clinical privileges he or she may exercise; and
- (4) any special conditions to the reappointment.

If, after a consideration of the recommendations of the various reviewing bodies, the Board denies the application for reappointment or increase in clinical privileges, the Chief Operating Officer shall notify the Member, in writing, of this denial and reasons therefore and shall also, in those instances in which the Member has a right to a hearing, inform the Member of the right to request, in writing, a hearing in accordance with Article 7 of these Bylaws within 30 days of receipt of the notice. Such notice shall be sent as provided in Section 19.04 (b), Special Notice.

A Member shall have a right to a hearing upon an action of the Board regarding reappointment or clinical privileges only if the Board votes to deny a request for reappointment or clinical privileges notwithstanding the Medical Executive Committee's recommendation in favor of reappointment or clinical privileges.

The fact that the Medical Executive Committee has recommended that the Member's application for reappointment or any increase in clinical privileges be granted shall not entitle the Member to reappointment or to any increase in clinical privileges.

## **G. Administrative Closure**

If a member of the Medical Staff fails to comply with Item C (5), Section 4.06, the Chairperson of the Department may recommend through the Credentials Committee an administrative closure of the appointment.

## **4.07 EXPEDITED INITIAL APPOINTMENT AND REAPPOINTMENT**

- a. If an Applicant or Member qualifies for an expedited initial appointment or expedited

reappointment in accordance with the standards in (b) below, the Medical Executive Committee shall have the discretion to bypass the Joint Conference Committee and forward its recommendation directly to the Quality and Patient Safety Committee of the Board for final decision on the application for initial appointment or reappointment.

b. An Applicant or Member qualifies for an expedited initial appointment or expedited reappointment if the following standards are met:

- (i) The Applicant or Member has submitted a completed application that contains all of the required forms, documents and information and the Credentialing Verification Office has completed all verification procedures;
  - (ii) The Department Chair of the Department to which the Applicant or Member will be or is appointed, the Credentials Committee and the Medical Executive Committee recommends that the application for initial appointment or reappointment be approved without any limitations;
  - (iii) In most instances, the Applicant or Member has not been the subject of any action by any licensing or regulatory agency of this or any other State or Federal agency against his or her license(s) to practice, license(s) or permit(s) to prescribe controlled substances or ability to participate in Medicaid, Medicare or any other Federal, State or third party sponsored payment program;
  - (iv) In most instances, the Application or Member has not been subject to any corrective or disciplinary action proceeding at the Hospital or any other health care facility; and
  - (v) In most instances, no final adverse judgment or settlement relating to professional activities or performance has been entered with respect to the Applicant or Member in a professional liability action.
- c. Notice of the action of the Quality and Patient Safety Committee for expedited initial appointment shall be given to the Applicant as set forth in Section 1 (c) (viii), Notice of Final Decision, of this Article.
- d. Notice of the action of the Quality and Patient Safety Committee approving an application for expedited reappointment shall be given to the Member as set forth in Section 2 (d) (xii), Notice of Final Decision, of this Article. If the Quality and Patient Safety Committee recommends that an application for expedited reappointment be denied, the procedures set forth in Article 7, Hearing Procedures, shall be followed.
- e. Notwithstanding that an Applicant or Member meets the standards for expedited initial appointment or reappointment under this Section, either the Department Chair, the Credentialing Committee, the Executive Medical Staff Committee, the President, the ~~Chief Medical Officer~~[Medical Director](#), the Chief Operating Officer, the CCHHS Chief Executive Officer, or the Board may require that an application for initial appointment or reappointment be processed as set forth in Section 1, Procedures for Appointment, or Section 4.06 (A), Application for Reappointment.



#### **4.08 LEAVE OF ABSENCE**

A Member, other than a Temporary or Provisional Member, may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Chairperson of the Department to which he or she is assigned and to the ~~Chief Medical Officer~~Medical Director. The request must state the reason for the leave and the exact dates for which leave is requested. If the Department Chairperson and the ~~Chief Medical Officer~~Medical Director approve the request, the Chairperson shall promptly notify the ~~Chief Medical Officer~~Medical Director, the Chief Operating Officer, the President of the Medical Staff, the Medical Executive Committee, and the Medical Staff Office of the exact dates during which the Member shall be on leave. A Member's leave of absence may not exceed one (1) year. During the period of the leave, the Member shall be excused from all staff duties and shall not exercise any staff or clinical privileges. An approved leave of absence from the Medical Staff shall not extend a Member's term of appointment.

### **ARTICLE 5: CATEGORIES OF THE MEDICAL STAFF**

#### **5.01 CATEGORIES**

The Medical Staff shall include the following membership categories: Active, Associate Active, Consulting, Temporary, Affiliate, Voluntary, Ancillary and Emeritus. All successful Applicants to the Medical Staff will be assigned to a membership category. Unless otherwise indicated, members of any of the following categories shall be obligated to pay dues in order to maintain their medical staff membership. Further, unless otherwise indicated, all references in this Article to eligibility to vote, hold elective office or serve on committees shall refer to the meetings, offices or committees of the Medical Staff.

#### **5.02 ACTIVE**

The Active category of the Medical Staff shall consist of Members who are in good standing, are board certified or board eligible or are otherwise qualified as stipulated by the Rules and Regulations of each Department in the relevant specialty area and meet the following criteria: regularly admit and attend in the Hospital or regularly provide services related to the Hospital and: (1) regularly care for patients in the Hospital's outpatient system; or (2) regularly provide teaching to the Residents and/or Staff at the Hospital; or (3) remain active in the Department and committee work of the Hospital's Medical Staff.

Members of the Active category of the Medical Staff shall be eligible to vote, hold elective office, and/or serve as committee Chairperson(s).

#### **5.03 ASSOCIATE ACTIVE**

The Associate Active category of the Medical Staff shall consist of practitioners who meet the criteria set forth above with respect to Active staff membership except that they do not regularly admit and attend patients in the hospital or regularly provide services related to the hospital and do



not fall within any of the other categories described in this Article. Associate Active Staff members shall attend meetings of the Medical Staff and the Department to which he or she is assigned as specified by Departmental Rules and Regulations as a condition of maintaining Associate Active Staff status. Members of the Associate Active category may admit and attend their patients in the Hospital only to the extent expressly permitted by Hospital policy.

A member of the Associate Active Staff shall not be eligible to vote, hold elective office or serve as committees, chairperson.

#### **5.04 CONSULTING**

The Consulting category of the Medical Staff shall consist of practitioners of recognized professional ability who provide services at the Hospital in an area of practice which is unusual or specialized and not regularly required at the Hospital. The members of the Consulting category of the Medical Staff shall render their services in the care of patients or education of staff when requested. The members of the Consulting category of the Medical Staff must be members in good standing of the Medical Staff of another Illinois licensed hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause.

Members of the Consulting category of the Medical Staff shall not be eligible to vote, hold elective office or serve as committee Chairperson(s).

#### **5.05 AFFILIATE**

The Affiliate Staff category of the medical staff shall consist of practitioners qualified for staff membership who are members in good standing of the medical staff of another Hospital operated by the County of Cook or practitioners who regularly care for patients in the Bureau's outpatient system and who are requested by the CCHHS Chief Executive Officer or designee to provide service at the Hospital on a limited or occasional basis. A member of the affiliate category shall not be required to pay dues, and shall not be eligible to vote, hold elective office or serve as committee chairperson.

#### **5.06 SPECIAL PROVISIONS APPLICABLE TO MEMBERS OF AFFILIATE CATEGORY**

In the event that an Affiliate member's, Active or Attending Medical Staff membership at another hospital within the System expires, is terminated, is suspended, or is restricted in any manner, the Affiliate membership at Provident Hospital of Cook County shall also expire, be terminated, restricted or suspended for a like period of time. The ~~Chief Medical Officer~~ [Medical Director](#) shall promptly notify the Affiliate member of this action. Such notification shall be in writing. In this event, the member shall have no right to a hearing or appeal of the expiration, termination or suspension of the Affiliate membership under these Bylaws.

In the event that the Affiliate member's clinical privileges at another hospital within the System are in any manner revoked, suspended, restricted or reduced, any equivalent Affiliate privileges at Provident Hospital of Cook County shall be revoked, suspended, restricted or reduced in the same

manner for a like period of time. The ~~Chief Medical Officer~~[Medical Director](#) shall promptly notify the Affiliate member of this action. Such notification shall be in writing. In this event, the member shall have no right to a hearing or appeal of the revocation, suspension, restriction or reduction of the Affiliate member's privileges under these Bylaws.

Nothing herein shall prohibit the imposition of corrective action with regard to the Medical Staff membership or clinical privileges of an Affiliate member of the Medical Staff. In the event the Affiliate member's Medical Staff membership at Provident Hospital of Cook County is terminated or suspended or his or her clinical privileges are revoked, suspended, restricted or reduced, the ~~Chief Medical Officer~~[Medical Director](#) shall promptly notify in writing the ~~Chief Medical Officer~~[Medical Director](#)s of any other hospital within the System where the Affiliate member holds Medical Staff membership. Such notification shall include the terms and nature of the corrective action.

Nothing herein shall prohibit a Medical Staff member who is in the Active category or Attending Staff category at another hospital within the System from being appointed to any other category of membership on the Medical Staff pursuant to the procedures set forth in these Bylaws.

#### **5.07 VOLUNTARY**

The Voluntary category of the Medical Staff shall consist of medical allopathic physicians, osteopathic physicians, dentists or podiatrists practitioners who shall be appointed to the Voluntary category of the Medical Staff as approved by the Credentials Committee, Medical Staff Executive Committee, ~~Chief Medical Officer~~[Medical Director](#) and Chief Operating Officer, provide services or participate in Hospital or Departmental activities, as requested by the Department Chairperson [and the President of the Medical Staff](#), without compensation. Members of the Voluntary category shall not be required to pay dues and shall not be eligible to vote, hold elective office or serve as committee chairperson(s).

#### **5.08 ANCILLARY**

The Ancillary category of the Medical Staff shall consist of Members who will provide clinical support to Medical Staff Departments under the general authority of the Department Chairperson. Members of the Ancillary category of the Medical Staff shall not be required to pay dues or attend medical staff meeting and shall not be eligible to vote, hold elective office or serve on committees.

#### **5.09 EMERITUS**

The Emeritus category of the Medical Staff shall consist of practitioners who shall be appointed to the Emeritus category either by virtue of achieving emeritus status by retirement in good standing, or as an act of recognition or honor by the Medical Staff for outstanding reputation or accomplishment. Members of the Emeritus category shall not be required to pay dues and shall have no assigned duties, shall not admit patients or be granted clinical privileges, and shall not vote, hold elective office or serve on committees.

## **5.10 CHANGES IN MEDICAL STAFF CATEGORY**

A Member (other than a provisional Member) who desires to be assigned to another category of the Medical Staff shall make a written request for such a change to the appropriate Department Chairperson for recommendation at the time he or she applies for reappointment to the Medical Staff or at any other time upon special written application. The request and the recommendation of the Department Chairperson will then be forwarded to the ~~Chief Medical Officer~~Medical Director for decision based on the Member's satisfaction of the criteria as outlined in this Article, subject to the approval of the Credentials Committee.

In addition, the ~~Chief Medical Officer~~Medical Director may notify the Member, at the time of transmittal to the Member of an application for reappointment, that his or her Medical Staff category shall be administratively changed with respect to any new term of appointment because the Member no longer meets the criteria associated with the category occupied during the current term of appointment. The ~~Chief Medical Officer~~Medical Director shall obtain approval from the Credentials Committee in advance of providing such notification. If, notwithstanding such administrative change, the Member applies for reappointment to the same category occupied prior to the application for reappointment, the recommendations of the ~~Chief Medical Officer~~Medical Director and the Credentials Committee against the Member's request for continued assignment to the relevant medical staff category shall be processed with the application for reappointment in accordance with the procedures set forth in Article 4, Section 4.04, Procedures for Appointment.

An evaluation of the requested change in Medical Staff category shall be based on the Member's satisfaction of the criteria with respect to each category of Medical Staff membership set forth in this Article. If the Member's request for a change in medical staff category is denied the Member shall have the right to request a hearing in regard to the denial pursuant to Article 7, Hearing Procedures.

## **ARTICLE 6: CORRECTIVE ACTION PROCESS**

### **6.01 INITIATION OF CORRECTIVE ACTION PROCESS**

(a) Corrective action may be initiated against any Member who engages in, makes, or exhibits acts, statements, demeanor or professional conduct either within or outside the Hospital which is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, or is below the standards and aims of the Hospital and the Medical Staff, or is disruptive to the operation of the Hospital, or would impair the community's confidence in the Hospital, or is in violation of the Hospital's Corporate Bylaws, the Policies and Procedures, these Bylaws, the Rules and Regulations or any Departmental rules, policies or procedures. The procedures specified herein shall not preclude the Hospital, through its Chief Operating Officer or ~~Chief Medical Officer~~Medical Director, from taking any direct action or utilizing other methods for dealing with disruptive or other conduct which action does not adversely affect Clinical Privileges or Membership.

(b) It shall be the duty of any Member, the Chief Operating Officer, the CCHHS Chief Executive Officer, or the Cook County Health and Hospitals System Board or any member thereof,

to make a prompt written report of activities or conduct of the type described in paragraph (a), immediately above. This written report shall be submitted to either the ~~Chief Medical Officer~~Medical Director or the Chief Operating Officer, either of whom shall determine whether the nature of the report is such that it requires an investigation. The ~~Chief Medical Officer~~Medical Director shall assign the investigation to an ad hoc committee composed of at least three individuals, two of whom must be medical staff members. This ad hoc committee shall be known as the Peer Review Committee.

## **6.02 THE PEER REVIEW COMMITTEE**

(a) The Peer Review Committee shall conduct its investigation within a reasonable time period which, except in unusual circumstances, shall not exceed thirty (30) days. Prior to formulating its report, the Peer Review Committee may have access to documents, medical records, the initiator of the investigation, individuals with knowledge of the alleged conduct and any other sources which would assist in the fact-finding process. The Peer Review Committee's investigation shall not be limited to the specific activities or conduct reported to it when its investigation reasonably discloses the need for a more comprehensive investigation in order to formulate its report. The Member against whom corrective action is being considered shall appear before the Peer Review Committee prior to the Committee's formulation of its report. At this appearance, the Member shall be informed of the general nature of the charges against him or her and shall be invited to discuss, explain, or refute them. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings or in the Hearing Procedure shall apply thereto. A summary of the discussion at this appearance shall be made by the Peer Review Committee and shall be included with its report. Upon the completion of the investigation, the Peer Review Committee shall issue its report to the Chief Operating Officer, the ~~Chief Medical Officer~~Medical Director and the Department Chairperson as well as to the Member. The report shall contain the recommendation(s) of the Peer Review Committee and shall include a summary of the Peer Review Committee's investigation and finding(s). If corrective action is recommended, the recommendation(s) shall be supported by reference to the activities or conduct which constitute the grounds for the recommendation(s). This report may be offered by any party to the Ad Hoc Hearing Committee pursuant to the Hearing Procedure.

(b) The report of the Peer Review Committee shall recommend one or more of the following:

(1) No corrective action is warranted;

(2) A letter of warning, admonition or reprimand be issued to the Member;

(3) The matter be resolved through the establishment of a consultant or supervisory relationship with the Member (such recommendation to include the person or persons responsible for consultation with or supervision of the Member), provided that no preauthorization is required prior to the exercise of Clinical Privileges, or to impose remedial measures which may include, but need not be limited to, training, education or counseling;

(4) Restoration of clinical privileges, where permissible, following a suspension pursuant to Section 6.04, Summary Suspension of Privileges, of this Article;

(5) The Member be placed on probation (such recommendation to include the length and conditions of probation);

- (6) A reduction, restriction, or revocation of the Member's clinical privileges;
- (7) A suspension of clinical privileges, granting credit for the any period of time during which the Member was summarily suspended; or
- (8) Termination of the Member's Membership.

(c) The ~~Chief Medical Officer~~Medical Director shall forward the report of the Peer Review Committee to the Medical Executive Committee for consideration at its next available meeting. If the Medical Executive Committee recommends any of the actions set forth in paragraph (b), subparagraphs (2) and (3), immediately above, the ~~Chief Medical Officer~~Medical Director shall refer the matter to the applicable Department Chairperson for implementation. If the Medical Executive Committee recommends any of the corrective actions set forth in paragraph (b), subparagraphs, (5), (6), (7) or (8), immediately above, or any combination thereof, the ~~Chief Medical Officer~~Medical Director shall notify the Member that he or she is entitled to the procedural rights set forth in the Hearing Procedure before final action is taken by the Cook County Health and Hospitals System Board. Such notice shall be as provided in Section 19.04 (b), Special Notice.

### **6.03 BOARD AUTHORITY**

The procedures specified herein shall not preclude the Cook County Health and Hospitals System Board from taking any direct action or utilizing other methods for dealing with disruptive or other conduct which action does not adversely affect Clinical Privileges or membership.

### **6.04 SUMMARY SUSPENSION**

(a) Whenever there are reasonable grounds to believe that the conduct or clinical activities or competence of a Member may pose a threat to the life, health or safety of patients, employees, or other persons present at the Hospital and where failure to take prompt action may result in danger to the life, health or safety of any such person, the Cook County Health and Hospitals System Board shall have the authority to summarily suspend any or all of the Clinical Privileges of such Member. In addition, the Chief Operating Officer, in consultation with the ~~Chief Medical Officer~~Medical Director and with the concurrence of the CCHHS Chief Executive Officer, shall also have the authority to summarily suspend any or all of the Clinical Privileges of such Member. Such summary suspension shall become effective immediately upon imposition and thereafter, the Chief Operating Officer shall promptly give notice of the suspension to the Member. Such notice shall be given as provided in Section 19.04 (b), Special Notice. The Chief Operating Officer shall immediately refer the matter of the summary suspension to a Peer Review Committee pursuant to Section 6.01(b) of this Article, Duty to Report, and the summary suspension shall remain in full force and effect unless lifted by the person(s) who imposed it or unless privileges are restored by the Medical Executive Committee after consideration of a Peer Review Committee preliminary recommendation as described in this Section 6.04. In the event the person(s) who imposed the summary suspension lift the summary suspension, the Peer Review Committee shall continue its investigation of the matter which gave rise to the summary suspension but shall no longer be required to complete a preliminary investigation within seven (7) business days as set forth in paragraph (b) of this Section 6.04, Summary Suspension. For purposes of these Bylaws, a

“summary suspension” shall refer to a prophylactic measure pending a complete investigation and shall not be construed as a corrective or adverse action. “Summary suspension” shall not constitute a suspension of clinical privileges as provided for in paragraph (b) of Section 6.02, The Peer Review Committee.

(b) Upon receipt of a report, the Peer Review Committee shall initiate its investigation in accordance with the procedure established in Section 6.02 of this Article. However, in the case of a summary suspension, the Peer Review Committee shall also, within seven (7) business days of receipt of the written notice of the summary suspension, conduct a preliminary investigation and transmit a written recommendation to the Medical Executive Committee stating whether the Member's Clinical Privileges should be restored or should remain summarily suspended pending the completion of the Peer Review Committee's investigation. Irrespective of its recommendation to the Medical Executive Committee regarding the summary suspension of clinical privileges, the Peer Review Committee shall continue its investigation until it is completed.

(c) If the Medical Executive Committee votes to restore all or any portion of the Clinical Privileges and if the person(s) who imposed the summary suspension concurs, or if the person(s) who imposed the summary suspension lift the summary suspension, such restoration shall take immediate effect without prejudice to the other proceedings pursuant to this Article or to Article 6.

#### **6.05 DISQUALIFICATION**

A Member who is the subject of a proceeding under this Article shall not be entitled to be present, take part in deliberations, or vote when any committee or body of which he or she is a member is acting in furtherance of such proceeding.

#### **6.06 SUSPENSION OF CLINICAL PRIVILEGES**

All clinical privileges, may be suspended by the ~~Chief Medical Officer~~[Medical Director](#) or President of the Medical Staff upon the occurrence of any of the following events:

- (1) The Member's license to practice is suspended or restricted, or a condition of any sort is placed upon such license; or
- (2) The Member's license or right to prescribe or administer any controlled substances is revoked, suspended or restricted in any manner.

#### **6.07 ADMINISTRATIVE SUSPENSION**

The President or the ~~Chief Medical Officer~~[Medical Director](#) may administratively suspend a Member's clinical privileges for the following reasons:

- (1) **Failure to Attend Mandatory Meeting(s)**

The unexcused failure or a Member to attend a mandatory meeting(s) pursuant to Article 15, Section 15.06 (D), Attendance Requirements.

- (2) **Incomplete Medical Records**

The unexcused failure of a Member to complete medical records within fifteen (15) days after written notice from the ~~Chief Medical Officer~~[Medical Director](#) delivered as set forth in Section 8, Notice to Member, of this Article. This provision shall not preclude the imposition of summary suspension pursuant to Section 6.04 Summary Suspension of Clinical Privileges, of this Article for Failure to complete medical



records, where appropriate.

## **6.08 LIFTING OF THE ADMINISTRATIVE SUSPENSION**

The individual who imposed the administrative suspension pursuant to this Section may determine when it will be lifted and notify the Member of such action.

## **6.09 AUTOMATIC TERMINATION**

(a) A Member's Membership, as well as all clinical privileges, shall be automatically terminated upon the occurrence of any of the following events:

- (1) The Member loses his or her license to practice his or her profession
- (2) The termination or expiration of the contract for the provision of services between the County and another institution, entity or person pursuant to which the Member provides physician services at the Hospital; or
- (3) The termination or expiration of the contractual or employment relationship between the Member and the institution, entity or person with which the County has contracted for the provision of physician services; or
- (4) A substantial modification of the contractual or employment relationship between the Member and the institution, entity or person with which the County has contracted for the provision of physician services, which modification substantially alters either the Member's availability or ability to perform required responsibilities at the Hospital.
- (5) The expiration or termination of a contract, including a written employment contract, between the Member and the County.
- (6) The inability or failure of the Member to secure, or to maintain, professional liability insurance as required by a contract to which the County is a party or as otherwise required by the Hospital.
- (7) Failure, without good cause, to return a completed, signed application for reappointment to the ~~Chief Medical Officer~~Medical Director at least thirty (30) days prior to the expiration of a Member's current period of appointment.
- (8) A Member's exclusion from participation in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act.

(b) Except for 6.07(1), The ~~Chief Medical Officer~~Medical Director may, for good cause, waive the automatic termination provisions of this Section 6.06, Automatic Termination, and may notify a Member in writing that his or her Medical Staff appointment and Clinical Privileges shall not terminate automatically but shall continue for its natural term or, if the ~~Chief Medical Officer~~Medical Director has extended to the Member a grant of interim clinical privileges as provided for in paragraph "E" of Section 4.05, Lapse in Privileges: Interim Clinical Privileges, for a specified period. This waiver shall be permitted for Members who are in the Active Category of the Medical Staff and who have notified the ~~Chief Medical Officer~~Medical Director of circumstances under which the ~~Chief Medical Officer~~Medical Director and the Chief Operating Officer agree the Member shall be permitted to continue to provide regular care to patients of the Hospital.

## **ARTICLE 7: HEARING PROCEDURES**

### **7.01 RIGHT TO A HEARING**

Any Member who is adversely affected by any of the following recommendations or actions, shall be entitled to a hearing:

- (a) Denial of reappointment to the Medical Staff;
- (b) Termination from the Medical Staff, except where the termination is pursuant to Section 6.06, Automatic Termination;
- (c) Any suspension from the Medical Staff other than a summary suspension;
- (d) Denial of advancement from the Provisional status to regular membership in the Active category of the Medical Staff;
- (e) Denial of a change in clinical privileges, except where the Member is requesting clinical privileges in a Department, subspecialty or service which has determined that it does not require the service which would be reflected by the additional privileges sought;
- (f) Suspension, other than summary suspension, restriction or revocation of or failure to renew clinical privileges;
- (g) A period of probation; or
- (h) Any other recommendation or action adversely affecting any Member other than a recommendation or action listed in Article 7, Section 7.02, Actions Not Giving Rise to Right to Hearing.

In the case of corrective action matters, a Member shall have a right to a hearing upon an action of the Board only where the Board votes to impose a more severe action than was recommended by the Medical Executive Committee and where the Member waived his or her right to a hearing, if any, at the time of the Medical Executive Committee's recommendation as set forth in Article 6, Section 6.02 of these Bylaws. In the case of matters other than corrective action, a Member shall have a right to a hearing upon an action of the Board only where the Board denies an application for reappointment or a change in clinical privileges notwithstanding the Medical Executive Committee's recommendation in favor thereof and the Member waived his right to a hearing, if any, at the time of the Medical Executive Committee's recommendation.

### **7.02 ACTIONS NOT GIVING RISE TO RIGHT TO A HEARING**

The following recommendations or actions with respect to a Member which do not give rise to a right to a hearing include but are not necessarily limited to:

- (a) The denial or revocation of interim or temporary privileges under Article 4, Section 4.05, Delineation of Clinical Privileges, Subsections (C) and (D), of these Bylaws;



- (b) Automatic termination under Article 6, Section 6.06, Automatic Termination, of these Bylaws except as provided in Section 7.01(b);
- (c) The imposition of supervision on a Member which does not require preauthorization prior to the exercise of Clinical Privileges;
- (d) The issuance of a letter of warning, admonition or reprimand;
- (e) Additional training, education or counseling;
- (f) Any recommendation or action not adversely affecting any Appointee

### **7.03 WHEN RECOMMENDATION OR ACTION DEEMED ADVERSE**

No adverse recommendation or action shall be deemed to have been made or taken in the following circumstances: (i) an informal investigation into any matter; (ii) the appointment of and investigation by a Peer Review Committee; or (iii) a request to an Member to appear at an informal interview or conference before the Medical Executive Committee, the Credentials Committee, any Department Chairperson, the ~~Chief Medical Officer~~Medical Director, the Peer Review Committee, the Chief Operating Officer, the CCHHS Chief Executive Officer, the Cook County Health and Hospitals System Board or any other Professional Review Body in connection with any investigation prior to a recommendation or action.

### **7.04 WHEN THE RIGHT TO A HEARING ARISES**

A recommendation or action shall give rise to the right to a hearing at the earliest of the following times, but not at any time prior thereto: (i) when the recommendation has been made by the Medical Executive Committee (except when voting whether to restore clinical privileges after summary suspension) or, (ii) when the Cook County Health and Hospitals System Board has taken action.

### **7.05 NOTIFICATION OF ADVERSE ACTION**

If any recommendation or action which gives rise to a hearing right under Article 7, Section 7.01, Right to a Hearing, of this Hearing Procedure is made or taken, the Chief Operating Officer shall be responsible for giving prompt written notice of the adverse recommendation or action to the Member. Such notice shall:

- (a) state the adverse recommendation or action which has been made or taken ;
- (b) include a statement of the reasons for the adverse recommendation or action;
- (c) inform the Member of his or her right to request a hearing under Article 7, Section 7.05, Request for Hearing, of these Bylaws;
- (d) inform the Member that a hearing must be requested within ~~fifteen~~thirty (~~15~~30) days from receipt of such notice;
- (e) state that, upon receipt of his or her request for a hearing, the Member will be notified of the date, time and place of the hearing, which date shall be not less than fifteen (15) days after the date of the notice;
- (f) include a copy of Article 7 of these Bylaws; and
- (g) state that failure to request a hearing within the time stated and in a proper manner constitutes a waiver of his or her right to a hearing and to an appellate review on the

matter that is the subject of the notice.

Such notice shall be given as provided in Section 19.04 (b), Special Notice.

#### **7.06 REQUEST FOR HEARING**

A Member's request for a hearing must be made in writing and either delivered personally or sent by certified mail, return receipt requested, to the Chief Operating Officer within ~~fifteen~~ thirty (1530) days of the Member's receipt of written notice of the adverse recommendation or action which gives rise to the right to a hearing.. By requesting a hearing, a Member confirms and agrees to be bound by the provisions of these Bylaws regarding immunities, releases from liability and confidentiality.

#### **7.07 RIGHT TO ONE HEARING AND APPELLATE REVIEW**

Notwithstanding any other provision of these Bylaws to the contrary, no Member shall be entitled as a matter of right to more than one hearing and one appellate review on any matter for which there is a hearing right. Adverse recommendations or actions on more than one matter may be consolidated and considered together or separately as the Chief Operating Officer and the ~~Chief Medical Officer~~ Medical Director shall designate jointly in their sole discretion.

#### **7.08 WAIVER BY FAILURE TO REQUEST A HEARING**

The failure of a Member to request a hearing to which he or she is entitled shall be deemed a waiver of the right to such hearing and to any appellate review. The effect of the waiver is as follows:

- (a) in the case of an adverse action by the Cook County Health and Hospitals System Board, the action shall become effective as its final decision; and
- (b) in the case of an adverse recommendation by the Medical Executive Committee, the recommendation shall become effective pending final action by the Cook County Health and Hospitals System Board

#### **7.09 NOTICE OF HEARING**

If a Member requests a hearing within the ~~fifteen-thirty~~ (1530) day period specified in Section 7.05, Request for Hearing, of these Bylaws, a Hearing Committee shall be appointed and the Chief Operating Officer shall select a hearing date and shall give the Member written notice which shall:

- (a) specify the date, time, and place of the hearing, which date shall be not less than thirty (30) days, nor more than forty-five (45) days after the date of this notice hearing;
- (b) list the members of the Hearing Committee;
- (c) list the witnesses (if any) expected to testify and the exhibits (if any) expected to be introduced at the hearing in support of the adverse recommendation or action;
- (x) Inform the Member that either party may serve a request for documents on the other

- party which are directly relevant to the conduct of the Member;
- (d) inform the Member that he or she has the duty to advise the Chief Operating Officer within seven (7) days of receipt of the notice of hearing as to whether he or she will be represented by counsel at the hearing;
  - (e) inform the Member that he or she has the duty to advise the Chief Operating Officer within seven (7) days of receipt of the notice of hearing if he or she believes that any voting member of the Hearing Committee do not meet the criteria for appointment to the Hearing Committee set forth in Article 7, Section 7.09, Membership of Hearing Committee, of these Bylaws;
  - (f) inform the Member that he or she will be required to provide a list of witnesses expected to testify on his or her behalf and a list of exhibits no later than ten (10) days before the first hearing session at which testimony will be taken; and
  - (g) state that the either party reserves the right to amend its list of exhibits and witnesses, and that, if amended, will promptly notify the other party and the Chair of the Hearing Committee of any such amendment . Such notice shall be deemed to have been duly given if given as provided in Section 19.04 (b), Special Notice.

## **7.10 MEMBERSHIP OF HEARING COMMITTEE**

The Chief Operating Officer and the ~~Chief Medical Officer~~[Medical Director](#) shall jointly appoint the Hearing Committee which shall consist of at least five (5) Members. The Chief Operating Officer and the ~~Chief Medical Officer~~[Medical Director](#) shall serve as a non-voting ex-officio member of the Ad Hoc Hearing Committee, shall be available for consultation and shall have the right to be heard throughout the hearing process. The Hearing Committee shall have no voting members (i) who actively participated in initiating or investigating the underlying matter at issue; or (ii) who had or shared responsibility for the adverse recommendation or action.

If the Member for whom the hearing has been scheduled advises the Chief Operating Officer within the seven (7) day period provided in Article 7, Section 7.08, Notice of Hearing, of these Bylaws that he or she believes a Member of the Hearing Committee does not meet the criteria of the previous paragraph, the Chief Operating Officer and the ~~Chief Medical Officer~~[Medical Director](#) may appoint a substitute to serve on the Hearing Committee. Failure of a Member to so advise the Chief Operating Officer shall be deemed a waiver of any objection to the membership of the Hearing Committee. If the Chief Operating Officer determines that the criteria for membership on the Hearing Committee as set forth above cannot be met by five (5) Medical Staff members, the Chief Operating Officer shall appoint a Hearing Committee consisting of three (3) Members.

In the event that one of the Hearing Committee members is unable to continue serving on the Committee and one of the parties objects to proceeding with fewer than the original number of members, the Chief Operating Officer and the ~~Chief Medical Officer~~[Medical Director](#) shall jointly appoint a replacement member. In this event, the transcripts and any documentary evidence from previous hearing sessions shall be made available to the replacement member who shall have an opportunity to review these documents prior to the Hearing Committee issuing its report.

## **7.11 QUORUM AND MANNER OF ACTION**

The presence of at least fifty percent (50%) of the voting members of the Hearing Committee shall constitute a quorum for purposes of each session of the Hearing Committee, except that in the case of a three (3) member committee, all three members must be present. Except for procedural or evidentiary rulings by the Chair during a session, any action taken by the Hearing Committee shall be by a majority of the voting members.

## **7.12 CONDUCT OF HEARING**

### **A. Presence of Member**

The personal presence of the Member for whom the hearing has been scheduled shall be required. If the Member who requested the hearing does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination. Any Member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her right to a hearing, with the same effect as set forth in Article 7, Section 7.07, Waiver by Failure to Request a Hearing, of these Bylaws.

### **B. Representation**

The Member who requested the hearing shall be entitled to be represented at the hearing by another Member in good standing, by a member of his or her local professional society, by an attorney, or by any other person of his or her choice. The Chief Operating Officer, shall appoint a representative for the Medical Executive Committee to present the facts in support of the adverse recommendation or action, and/or to examine witnesses. The Chairman of the Board shall appoint a representative for the Board to present the facts in support of the adverse recommendation or action, and/or to examine witnesses. The Chairman may delegate to the Chief Operating Officer the power to appoint the Board's representative. The Board or the Medical Executive Committee may be represented at the hearing by counsel. However, the Board or the Medical Executive Committee shall be represented by counsel if the Member is represented at the hearing by counsel.

### **C. Rights of Participants**

The hearing before the Hearing Committee shall be held on the date set in the notice of hearing given pursuant to Article 7, Section 7.08, Notice of Hearing, of these Bylaws. However, the Member may submit a written request for an extension of time, for cause, for a reasonable period, which will be allowed at the Chief Operating Officer's discretion.

On the first date set for the hearing, the Member and his representative, if any, and the Medical Executive Committee or Board representative and attorney, if any, shall attend a pre-hearing conference with the Hearing Committee presided over by the Hearing Committee Chair. The hearing shall be considered to have commenced as of the date of the pre-hearing conference. At this conference the Hearing Committee Chair shall:

a. preside over an exchange of documentary evidence to be presented by both parties, exclusive of rebuttal evidence, and facilitate access, where possible, to relevant information or

documents;

- b. receive any stipulations by the parties;
- c. consider any motions or objections from either party; and
- d. schedule future hearing sessions.

At the hearing, each participant shall have the following rights:

- (1) To testify on his or her own behalf and to call and examine witnesses who agree to appear on his or her behalf;
- (2) To cross-examine any witness on any matter relevant to the issues;
- (3) To introduce exhibits and documents relevant to the issues; and
- (4) To rebut any evidence.

#### **D. Hearing Committee Chair**

The Chief Operating Officer and the ~~Chief Medical Officer~~[Medical Director](#) shall jointly appoint one of the Hearing Committee members as the Chair for the Hearing Procedure. The Chair shall act as presiding officer of the Hearing Procedure to maintain decorum and to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and written evidence. The Chair shall be entitled to determine the order of proceeding during the hearing, to establish a schedule for the completion of the hearing, to promulgate rules and procedures not inconsistent with these Bylaws, to exclude or remove any person who is disruptive to an orderly and professional hearing, and to refuse to admit evidence which is not relevant to the subject matter of the hearing. The Chair may require that oral testimony be given upon an oath and affirmation administered by a notary public or other public official or may require that testimony be provided by affidavit due to time or witness availability constraints. Service as Chair by the member of the Hearing Committee shall not in any way prevent such member from full participation in the deliberations and actions of the Hearing Committee.

#### **E. Presentation of Evidence**

The hearing need not be conducted strictly according to the rules of law relating to the conduct of trials, examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible over objection in a civil or criminal proceeding. The Member for whom the hearing is being held shall, at or prior to the close of the hearing, be entitled to submit a written statement concerning any issue, procedure or fact and such memoranda shall become a part of the hearing record.

New or additional matters or evidence not raised or presented during the hearing and not reflected in the record shall not be permitted to be introduced after the conclusion of the hearing, except under unusual circumstances, and then only if the new or additional matters or evidence were not reasonably available at the time of the initial hearing before the Hearing Committee. Such new or additional matters or evidence must relate to the same facts and circumstances which formed the subject matter at the initial hearing before the Hearing Committee. Any party requesting consideration of such new or additional evidence shall direct such request, in writing, to

the Chief Operating Officer prior to the issuance of the report of the Hearing Committee.

#### **F. Official Notice**

The Hearing Committee may take official notice, either before or after submission of the matter for recommendation, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Illinois. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Every party shall have the opportunity to request that a matter be officially noticed or to refute that a matter be officially noticed, by presenting written or oral authoritative evidence, provided such action is taken prior to the conclusion of the hearing in the manner specified by the Hearing Committee. Additionally, the Hearing Committee shall be entitled to consider any information presented or developed during the appointment or reappointment process.

#### **G. Order of Presentation; Burden of Proof**

The body which made the recommendation or took the action which is the subject of the hearing shall have the initial obligation to present evidence in support of its action or recommendation. The Member shall thereafter have the burden of proving, by clear and convincing evidence, that the adverse action or recommendation either lacks any factual basis or, if there is a factual basis, that in light of the facts, the adverse action or recommendation is arbitrary, capricious or unreasonable.

#### **H. Recess and Reconvention of Hearing**

The Hearing Committee may, at its discretion and without special notice, recess the hearing for a brief period of time and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be concluded and the record shall be closed. The Hearing Committee shall then conduct its deliberations outside the presence of the parties and shall make its findings, conclusions and recommendations.

#### **I. Timely completion of Hearing**

The ~~Chief Medical Officer~~[Medical Director](#) or the Chief Operating Officer shall have the authority to require the Committee to meet on a more frequent schedule and to replace one or all members of the Hearing Committee if the schedules of members of the Hearing Committee prevent the completion of a hearing within a reasonable time frame.

### **7.13 RECORD OF HEARING**

The Hearing Record shall consist of:

- a. an accurate verbatim record of all hearing sessions made by a court reporter;

- b. the Credentials Committee of Peer Review Committee Report, if any;
- c. the action or recommendation of the body which gave rise to the right to a hearing;
- d. exhibits admitted during the hearing;
- e. any written motions or statements submitted by the parties during the hearing; and
- f. the Hearing Committee's Report.

The Hospital shall bear the cost of the original transcript and each party shall bear the cost of their copy of the transcript.

#### **7.14 REPORT OF THE HEARING COMMITTEE; CONSIDERATION BY MEDICAL EXECUTIVE COMMITTEE AND BOARD**

Within fifteen (15) days following the conclusion of the hearing, the Hearing Committee shall issue a Report to the Medical Executive Committee and shall send a copy of such report to the Chief Operating Officer and to the Member. Such report shall set forth the Hearing Committee's findings of fact, if any, and its conclusion as to whether the Member has shown by clear and convincing evidence that the recommendation or action lacks any factual basis or that if there is a factual basis, in light of those facts, the recommendation or action is arbitrary, capricious or unreasonable. If the Hearing Committee concludes that the Member has not met his or her burden of proof, the Report shall contain the Hearing Committee's recommendation regarding the Member's application for reappointment or for corrective action.

Within thirty (30) days of its receipt of the report of the Hearing Committee, the Medical Executive Committee shall review the Report. The Medical Executive Committee may adopt all or part of the Report of the Hearing Committee; may confirm its original recommendation; or, may issue a different recommendation including the reasons therefore. In the event the Medical Executive Committee votes to take an action which would not have given rise to a hearing in the first instance, the action shall be final and shall be implemented. In all other cases, the Chief Operating Officer shall transmit the Hearing Record to the Cook County Health and Hospitals System Board together with the Medical Executive Committee's recommendation based upon its review of the Hearing Committee's Report. At its next regular meeting, or as soon thereafter as is practicable, the Cook County Health and Hospitals System Board shall take action on the matter. In taking action, the Board may adopt the Hearing Committee Report or adopt the findings of the Hearing Committee and the recommendation of the Medical Executive Committee or may issue its own findings, conclusion and final action. The Chief Operating Officer shall notify the Member and the Medical Executive Committee of the decision of the Board, as provided in Section 19.04 (b), Special Notice, within five (5) days after the decision is voted upon. Such notice shall indicate that, unless an appellate review of the Board's decision is requested, the decision of the Board shall be final as of the date of the Board's action.

#### **7.15 REQUEST FOR APPELLATE REVIEW; RECOMMENDATION BY JOINT CONFERENCE COMMITTEE**

##### **A. Request for Appellate Review**

Within fifteen (15) days after such party's receipt of the notice of the action of the Board , either the Member or the Medical Executive Committee, through its Chairperson, may request an appellate review of the Board's decision by an appellate review panel of the Joint Conference Committee. Requests for an appellate review must be made in writing and either delivered personally or sent by certified mail, return receipt requested, to the Chief Operating Officer. Requests for appellate review must indicate whether an opportunity to make an oral presentation to the appellate review panel is requested and must be accompanied by a written statement detailing the reasons why the party requesting the appellate review disagrees with the initial Board decision. This written statement shall be no longer than fifteen (15) pages and may address only matters in the record. A copy of the request for appellate review together with the written statement shall be sent to the other party, which may submit a written response to the Chief Operating Officer and must send a copy to the other party, within ten (10) days after receipt of the appealing parties written statement. For good cause, the Chief Operating Officer may extend the time for submitting either the written statement or response thereto. The Chief Operating Officer shall transmit all requests for appellate review, together with the written statement in support thereof and the responses and any requests for an opportunity to make an oral presentation, to the Joint Conference Committee together with the Report of the Hearing Committee and a copy of the notice of the Board's decision.

**B. No Request for Appellate Review**

If neither the Member nor the Medical Executive Committee request an appellate review pursuant to this Section 7.14, Request for Appellate Review, of these Bylaws, the decision of the Board shall be final as of the date of the Board's action.

**7.16 APPELLATE REVIEW PROCEDURE**

**A. Notice of Appellate Review; Oral Presentations**

Upon receipt of a request for appellate review concerning which an oral presentation is requested, the Chief Operating Officer shall provide the parties with written notice of the date, time and place of the oral presentation which date shall not be less than twenty (20) days from the date the receipt of the written response as set forth in Section 7.14 (A), Request for Appellate Review. If an oral presentation was requested by either party, both parties shall be permitted to make an oral presentation to the appellate review panel, which presentation may be made by counsel for a party. The Member shall attend any such oral presentations and shall respond to any questions by the appellate review panel.

**B. Scope of Review**

The appellate review shall be held solely upon the Hearing Record, including the written statements of the parties submitted pursuant to Section 7.16, Request for Appellate Review, and any oral arguments, and shall not be a hearing de novo. The sole question to be decided on appellate review shall be whether the appellate review panel should recommend that the Board reconsider its decision, in light of the Hearing Record.



### **C. Appellate Review Panel**

The Joint Conference Committee shall act as the appellate review panel unless its Chairperson elects to appoint a subcommittee of the Joint Conference Committee to serve as the appellate review panel, which subcommittee shall consist of at least three voting members of the Joint Conference Committee, at least two of whom shall be Directors. The presence of fifty percent (50%) of the total voting membership of the appellate review panel shall constitute a Quorum for purposes of convening the appellate review panel. Any action taken by the appellate review panel shall be by a majority of the voting members.

### **D. Report of Appellate Review Panel**

Within forty-five (45) days after its receipt of the request(s) for appellate review and any written statements and responses, or as soon thereafter as practicable, the appellate review panel shall complete its deliberations and submit a written report to the Cook County Health and Hospitals System Board.

## **7.17 ACTION BY COOK COUNTY HEALTH AND HOSPITALS SYSTEM BOARD AFTER APPELLATE REVIEW**

If an appellate review is requested, the initial action of the Cook County Health and Hospitals System Board shall not be considered final. Following its receipt of the report of the appellate review panel, the Cook County Health and Hospitals System Board shall consider the report and take final action which shall be effective as of the date the Board takes its final action.

The Chief Operating Officer shall notify the Member of the final action of the Cook County Health and Hospitals System Board, as provided in Section 19.04 (b), Special Notice, within five (5) days after the decision is voted upon. Such notice shall state specific reasons for the decision, that the Board's action is final and it is effective as of the date of that action and shall not be subject to any further hearing or appellate review under these Bylaws.

## **ARTICLE 8: AUTHORIZATIONS — RELEASES — CONFIDENTIALITY AND IMMUNITY**

### **8.01 SPECIAL DEFINITIONS**

For the purposes of this Article, the following definitions shall apply:

#### **a. Information**

A record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written, oral, electronic or video form relating to any of the subject matter specified in Section 5(b), Information, of this Article.

#### **b. Practitioner**

An Applicant, current or former Member, or current or former Non-Member Practitioner.

**c. Representative**

A member of the Board and any committee thereof; the CCHHS Chief Executive Officer, the Medical Director, the Medical Staff and any Member, Officer, Department, Division, Section or Committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions pursuant to these Bylaws and the Rules and Regulations.

**d. Third Parties**

Both individuals and organizations not otherwise defined in (b) or (c) above providing information to any Representative.

**8.02 AUTHORIZATIONS AND CONDITIONS**

By submitting an application for initial appointment or reappointment to the Medical Staff, or exercising clinical privileges or providing specified patient care services within this Hospital, a Practitioner:

- a. authorizes Representatives to solicit, provide and act upon information bearing on his or her professional ability and qualifications;
- b. agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article; and
- c. acknowledges that the provisions of this Article are express conditions to his or her application for initial appointment or reappointment to the Medical Staff or his or her exercise of clinical privileges or provision of specified patient services at this Hospital.

**8.03 CONFIDENTIALITY OF INFORMATION**

Information with respect to any Practitioner submitted, collected or prepared by any Representative for the purpose of achieving and maintaining a desired level of patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and not be disseminated to anyone other than a Representative nor used in any way except as provided herein or required by law. Such confidentiality shall also extend to information of like kind that may be provided by Third Parties. This information shall not become part of any particular patient's file or of the general Hospital records.

**8.04 IMMUNITY FROM LIABILITY**

**a. For Action Taken**

Member or Non-Member Practitioner agrees that he or she shall not seek to hold a Representative liable in any Federal or State administrative or judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a Representative, if such Representative acts in good faith and without malice and in the reasonable belief that the action, statement, or recommendation is warranted.

**b. For Providing Information**

Member or Non-Member Practitioner agrees that he or she shall not seek to hold a Representative or Third Party liable in any Federal or State administrative or judicial proceeding for damages or other relief by reason of providing Information, including otherwise privileged or confidential information, to a Representative or to a Third Party concerning a Practitioner provided that such Representative or Third Party acts in good faith and without malice.

**c. Relief**

If a Member or Non-Member Practitioner files an action of any kind against a Representative or Third Party in any Federal or State administrative or judicial proceeding contrary to (a) or (b) above, such Member or Non-Member Practitioner consents to the entry of an order, or other directive appropriate to the forum in which the action was brought, of dismissal with prejudice.

**8.05 ACTIVITIES AND INFORMATION COVERED**

**a. Activities**

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

- (i) an application for initial appointment or reappointment and requests for clinical privileges;
- (ii) periodic appraisals for reappointment or clinical privileges;
- (iii) corrective action;
- (iv) hearings and appellate reviews;
- (v) patient care audits;
- (vi) utilization reviews and quality assurance activities;
- (vii) applications for Clinical Privileges or Collaborative Clinical Privileges by Non-Member Practitioners and corrective actions relative to Non-Member Practitioners;
- (viii) other Hospital or Medical Staff Committee, Department, Division or Section activities related to monitoring and maintaining the quality of patient care and appropriate professional conduct; and
- (ix) Institutional Review Board or Officer of Research Integrity reviews or investigations.

**b. Information**

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Member's or Non-Member Practitioner's professional

qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

#### **8.06 RELEASES**

Each Member or Non-Member Practitioner shall, upon request of the Hospital or Medical Staff, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of such releases shall not be deemed a prerequisite to the applicability of this Article.

#### **8.07 CUMULATIVE EFFECT**

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

### **ARTICLE 9: MEDICAL STAFF OFFICERS**

#### **9.01 OFFICERS**

The Officers of the Medical Staff shall be:

President;  
Vice-President;  
Secretary; and  
Treasurer.

#### **9.02 QUALIFICATIONS OF OFFICERS**

All officers must be active members of the Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

#### **9.03 ELECTION OF OFFICERS**

(a) Officers shall be elected at the annual meeting of the Medical Staff. Only active members of the Medical Staff shall be eligible to vote.

(b) Officers shall be elected from a slate of candidates offered by the Nominating Committee, which shall include one or more nominees for each office. The Nominating Committee's slate of candidates shall be posted on the Medical Staff bulletin board at least one (1) month prior to the Medical Staff meeting at which officers are elected. Not less than ten (10) days before the meeting at which officers are elected, any ten (10) members of the Active Medical Staff may file with the Medical Affairs Office a written nomination of one or more candidates for such offices together with the written consent of such candidate(s) to serve if elected. The Medical

Affairs Office shall promptly post such nominations on the Medical Staff bulletin board. Nominations shall not be permitted from the floor at the Annual Meeting.

(c) Voting shall be by secret ballot cast in person at the Annual Meeting or any meeting at which officers are elected. Ballots will be counted by the any of 2 of the following: Medical Staff Officers and/or Members at Large whom are not currently on the ballot. Request for a recount by a candidate or officer must be made in writing indicating the reasons within 10 days to the outgoing Nominating Committee which must be completed within 30 days of such request. All ballots must be secured by the ~~Chief Medical Officer~~Medical Director in a secured location for 30 days. Election total results will be released at the meeting. The majority of all votes cast at a meeting at which a quorum is present shall be necessary for election. If no candidate receives a majority, the candidate having the least number of votes shall be eliminated and balloting shall continue in such manner until a majority is obtained.

#### **9.04** **TERM OF OFFICE**

Except as otherwise provided in these Bylaws, the term of office for all officers shall be two (2) calendar years. Any member voted into office as per these Bylaws shall be eligible to serve in the same office for no more than two consecutive terms. Newly elected officers shall take office upon their election.

#### **9.05** **VACANCIES IN OFFICE**

Vacancies in an office of the Medical Staff shall be filled by the Medical Executive Committee. Such appointments shall be effective for the remainder of the term only. Notwithstanding, if the office of the President becomes vacant, the Vice President shall fill the vacancy for the remainder of the term. In the event the Medical Executive Committee, in its sole discretion, determines that an officer is unwilling or unable to perform his or her duties as an officer, the Medical Executive Committee shall have the right to remove that officer and to appoint a replacement for the remainder of the term.

#### **9.06** **REMOVAL FROM OFFICE**

(a) Any officer who commits actions that are against the interests of the medical staff or hospital or who is grossly negligent of his/her official duties may be subject to removal. Examples of permissible bases of removal of a medical staff officer include but are not limited to the following:

1. Failure to perform the duties of the position held in a timely and appropriate manner.
2. Failure to continuously satisfy the qualifications for the position.
3. Having an automatic or summary suspension imposed.
4. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.
5. Conviction of a felony.

Any request for the removal of a Medical Staff officer, other than as set forth in Article 9,

Section 9.05, Vacancies in Office, of these Bylaws must be submitted to the Medical Executive Committee by an active member of the Medical Staff, together with the signatures of at least twenty (20) active Medical Staff members in good standing to support said request. A request for the removal of a Medical Staff officer pursuant to this Section also may be submitted by at least seven (7) members of the Medical Executive Committee.

(b) The request for removal shall be reviewed by the Medical Executive Committee at its next Regular Meeting. A two-thirds (2/3) majority vote by the Medical Executive Committee in favor of removal is required before the question of removal may be placed before the active members of the Medical Staff.

(c) In the event that at least a two-thirds (2/3) majority of the Medical Executive Committee has voted in favor of removal, a vote of the active medical staff members shall be required. An officer of the Medical Staff shall be removed from office upon the vote of two-thirds (2/3) majority of those present and entitled to vote upon a motion made at any Regular Meeting of the Medical Staff or at a Special Meeting called for that purpose where a quorum is present. A quorum for removal shall be the same as the quorum for election described in Section 9.03, Election of Officers, of this Article.

(d) The Medical Staff officer in question shall not have any rights to a hearing and appeal under these Bylaws as a result of being removed from office. However, such removal shall not itself constitute a diminution of the officer's medical staff appointment or clinical privileges.

(e) The Secretary of the Medical Staff shall give written notice to the Chief Operating Officer, the CCHHS Chief Executive Officer, the Cook County Health and Hospitals System Board and to the involved officer of the removal from office.

## **9.07 DUTIES OF MEDICAL STAFF OFFICERS**

### **A. President**

The President shall:

- (1) Act in coordination and cooperation with the Chief Operating Officer and the Chief Medical Officer in all matters of mutual concern within the Hospital;
- (2) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- (4) Serve as the Chairperson of the Medical Executive Committee;
- (5) Be responsible for the enforcement of Medical Staff Bylaws and Rules and Regulations, for implementation of sanctions for non-compliance where these are stipulated, and for the Medical Staff's compliance with the procedural requirements in those instances where corrective action has been requested against an Member;
- (6) Appoint committee members and, except where otherwise specified, committee chairpersons to all medical staff committees;
- (7) Serve as an ex-officio member of all medical staff committees, unless otherwise provided;
- (8) Represent the views, policies, needs and grievances of the Medical Staff to the Cook County Health and Hospitals System Board, the CCHHS Chief Executive Officer and the Chief Operating Officer;

- (9) Represent the Medical Staff, by attendance and voice, at the meetings of the Joint Conference Committee;
- (10) Serve as the responsible representative of the Medical Staff to receive, understand and interpret the policies of the County, System and Hospital to the Medical Staff and to report and interpret to the Cook County Health and Hospitals System Board, in return, on the performance and maintenance of its delegated responsibility to provide quality medical care;

#### **B. Vice President**

- a. In the absence of the President, the Vice President shall assume all the duties and have the authority of the President.
- b. The Vice President shall be a member of the Medical Executive Committee and shall be expected to perform such duties as may be assigned to him or her by the President.
- c. The Vice President shall also be a member of the Joint Conference Committee.

#### **C. Secretary**

- (1) The Secretary shall be the Secretary of the Medical Executive Committee and keep accurate and complete minutes of all Medical Staff meetings.
- (2) The Secretary shall maintain a current list of all Members and members of the Medical Executive Committee.
- (3) The Secretary shall forward minutes of the meetings of the Medical Staff to each member within 30 days following each such meeting.

Minutes of the Medical Executive Committee meetings shall be provided by the Secretary prior to the next regular meeting of the Medical Executive Committee.

- (4) The Secretary shall attend to all correspondence and perform such other duties as ordinarily pertain to this office.
- (5) The Secretary shall assist the Medical Staff Office in compiling, updating and maintaining a file of the reports of all standing committees of the Medical Staff.
- (6) The Secretary shall be a member of and report the proceedings of the Joint Conference Committee to the next Medical Executive Committee meeting.
- (7) In the absence of the President and Vice-President, the Secretary shall become the President Pro-Tempore.

#### **D. Treasurer**

- (1) The Treasurer shall collect annual staff dues and keep accurate and complete records of collections and expenditures of these and any other funds or assessments that shall become the property of the Medical Staff.
- (2) The Treasurer shall prepare and transmit a quarterly report of the staff accounts to the

Medical Executive Committee and the Medical Staff.

(3) The Treasurer shall be a member of the Medical Executive Committee and of the Joint Conference Committee.

(4) In the absence of the Vice-President and the Secretary, the Treasurer shall become the President Pro-Tempore.

## **ARTICLE 12: MEDICAL STAFF MEETINGS**

### **12.01 MEDICAL STAFF MEETINGS**

#### **A. Annual Meeting**

The Annual Meeting of the members of the Medical Staff shall be held on the second Tuesday in January each year, at a time determined by the President of the Medical Staff. The President of the Medical Staff shall attempt to give at least one (1) month notice of the time and place of the Annual Meeting to all members of the Medical Staff. At the meeting where election of officers is to occur, the retiring officers and committees shall make such reports as may be appropriate and officers for the ensuing year shall be elected.

#### **B. Regular Meetings**

Quarterly meetings of the members of the Medical Staff shall be held on the second Tuesdays of January (the Annual Meeting), April, July, and October each year beginning at an hour to be determined by the President of the Medical Staff for purposes of hearing reports from the committees and Department chairpersons, analyzing the clinical work at the Hospital and transacting the general business of the Medical Staff. A Member who is entitled to vote on any matter at such meeting may, in writing presented to the Secretary, permit a Member who is also entitled to vote, to vote on her or his behalf on a matter that has been included in the meeting notice required by Section 12.02, Notice.

#### **C. Special Meetings**

Special Meetings of the Medical Staff may be called at any time by the Cook County Health and Hospitals System Board, the CCHHS Chief Executive Officer, the Chief Operating Officer, the President of the Medical Staff, the Medical Executive Committee, or not less than twenty-five percent (25%) of the active members of the Medical Staff. The business transacted in these Special Meetings shall be limited to the purpose for which the meeting is called. The notice of Special Meetings shall state the purpose for which the meeting is called and only the business for which the meeting was called will be considered.

### **12.02 NOTICE**

With the exception of notice of the Annual Meeting of the Medical Staff, written or printed notices stating the place, date and hour of any meeting of the Medical Staff shall be delivered either personally, by intra-hospital mail or by United States mail to members of the Medical Staff



not less than five (5) days nor more than forty (40) days from the date of such meeting. If sent by United States mail, a notice of a meeting shall be deemed to be delivered when deposited in the United States mail, addressed to the member at his or her address as it appears in the records of the Hospital with postage thereon prepaid. The attendance of any member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

### **12.03 QUORUM**

The presence of fifty (50%) percent of the total membership of the active members of the Medical Staff at any Annual, Regular or Special Meeting shall constitute a quorum for purposes of carrying out the business of the Medical Staff.

### **12.04 MANNER OF ACTION**

The action of a majority of the Medical Staff present and eligible to vote at a meeting at which a quorum is present shall be the action of the Medical Staff unless otherwise specified in these Bylaws. There shall be no proxy voting.

### **12.05 ATTENDANCE REQUIREMENTS**

Each member of the Medical Staff is expected to attend at least two (2) quarterly meetings of the Medical Staff each year unless otherwise specified. The Secretary of the Medical Staff shall compile a list of members who are present, excused or absent from such meetings. A member who is compelled to be absent from any quarterly meeting shall promptly submit to the Medical Staff office, in writing, his or her reasons for such absence and request that his or her absence be excused. Failure to meet the attendance requirements of this Section may be grounds for corrective action pursuant to these Bylaws and will be reported to the Credentials Committee at the time of the reappointment of the Member.

### **12.06 MEETING AGENDA**

#### **A. Regular Meetings**

The agenda at any Regular Meeting, including the Annual Meeting, of the Medical Staff shall be:

- (a) Administrative
  - (1) Call to order;
  - (2) Acceptance of the minutes of the last Regular and of all Special Meetings;
  - (3) Unfinished business;
  - (4) Announcements
  - (5) New business
  - A. Chief Operating Officer's Report
  - B. ~~Chief Medical Officer~~ Medical Director
  - C. President of Medical Staff
  - D. Treasurer's Report
  - E. Any special report deemed necessary by the Medical Staff President.

- (b) Professional
  - (1) Review and analysis of the clinical work of the Hospital;
  - (2) Report of standing and special medical staff committees when appropriate;
  - (3) Discussion and recommendations for improvement of the professional work of the Hospital;
  - (4) Educational Program; and
  - (5) Adjournment

## **B. Special Meetings**

The agenda at any Special Meeting of the Medical Staff shall be:

- (1) Communication of reason for special meeting;
- (2) Transaction of business for which the meeting was called; and
- (3) Adjournment.

# **ARTICLE 13: DEPARTMENTS**

## **13.01 DESIGNATION OF DEPARTMENTS**

The Departments of the Medical Staff shall include:

- (a) Anesthesiology;
- (b) Emergency Medicine;
- (c) Family Medicine;
- (d) Internal Medicine;
- (e) Obstetrics and Gynecology;
- (f) Pathology;
- (h) Diagnostic Imaging and Nuclear Medicine and;
- (i) Surgery.

## **13.02 DEPARTMENTS**

The Medical Staff, through the Medical Executive Committee, may forward to the Joint Conference Committee a recommendation that the Cook County Health and Hospitals System Board establish or abolish Departments. In order to be a Department, there shall be practitioner(s) actively engaged primarily in that area available to participate in accomplishing functions assigned to the Department. The above criteria and such others as may be deemed appropriate shall be used by the Medical Executive Committee in making a recommendation whether to establish or abolish Departments. The Medical Executive Committee recommendation shall be forwarded to the Chief Operating Officer for his or her recommendation. Both recommendations shall be forwarded to the CCHHS Chief Executive Officer for consideration. If the CCHHS Chief Executive Officer recommends any action, such recommendation shall be forwarded to the Cook County Health and Hospitals System Board for final approval. The above notwithstanding, the Cook County Health and Hospitals System Board may, on its own initiative, propose the establishment or abolishment

of a Department which proposal shall be forwarded to the Chief Operating Officer who shall refer the matter to the Medical Executive Committee for consideration and recommendation in accordance with the procedures set forth in this Section.

### **13.03 DEPARTMENT PROCEDURES**

Each Department shall formulate such rules, regulations, policies and procedures as are necessary to fulfill the functions and responsibilities of the Department and Department Chairperson. These rules, regulations, policies and procedures shall be submitted to the Medical Executive Committee for review and recommendation, and forwarded to the Cook County Health and Hospitals System Board for final approval.

### **13.04 ASSIGNMENTS TO DEPARTMENTS**

The Credentials Committee shall, after consideration of the recommendation of the clinical Departments, recommend initial Department assignment for all Medical Staff members to the appropriate committees and to the Cook County Health and Hospitals System Board, as specified in the Appointment Procedure in Article 4 of these Bylaws. For the purpose of carrying out Department responsibilities, each member of the Medical Staff shall be assigned to one Department, but may be granted clinical privileges in more than one Department. The exercise of clinical privileges within each Department shall be subject to the rules and regulations of that Department. It is the responsibility of the Department Chairperson to review the educational and training experience of the Applicant or Member who is seeking privileges in the respective Department and make appropriate recommendations. Clinical work performed in each Department shall be included in that Department's evaluation activities, regardless of the Department assignment held by the Member providing care, to ensure that all patients with the same health problems receive the same level of care.

### **13.05 FUNCTIONS OF DEPARTMENTS**

#### **A. Privileges**

Each clinical Department shall be responsible for (i) recommending clinical privilege categories and the standards of qualification to the appropriate committees and to the Cook County Health and Hospitals System Board, as specified in the Appointment Procedure in Article 4 of these Bylaws, and (ii) recommending to grant, delineate or deny clinical privileges in its own Department.

#### **B. Quality Review**

Each clinical Department shall perform the following functions which shall be conducted by Departmental committees, in their capacities as designees of, the Medical Staff's Quality Assessment and Improvement Committee:

- (1) Identification of the important aspects of care provided by the Department;
- (2) Identification of indicators to be used to monitor the quality of care;
- (3) Evaluation of the care provided;

- (4) Review of the care provided by the Department members to draw conclusions, formulate recommendations, and initiate action for the purpose of improving the quality of patient care and to reduce morbidity and mortality;
- (5) Communication to appropriate members of the Department or medical staff the findings, conclusions, recommendations, and actions taken to improve the quality of patient care and to reduce morbidity and mortality; and
- (6) Patient records and other pertinent sources of medical information relating to patient care shall be reviewed for the purpose of (i) selecting cases for presentation which will contribute to improving the care provided to patients by Members and (ii) encouraging frank discussion and developing criteria to assess and improve care.
- (7) Review and evaluate the professional performance of practitioners within the department in both a focused, time-limited manner through a Focused Professional Practice Evaluation (FPPE) for practitioners without current performance documentation at the organization or in response to concerns regarding the provision of safe, high quality patient care and on an ongoing basis through an Ongoing Professional Practice Evaluation (OPPE) to evaluate current competency and to identify professional practice trends that impact on quality of care and patient safety.

### **C. Meetings**

Departmental meetings will be held at least quarterly to review and evaluate the medical performance of the Department, including the quality assessment and improvement activities of the Department, on a peer-group basis, as set forth in Article 13, Section 13.06(B), Functions of Department Chairperson, Subsection (4). Such reviews may include consideration of deaths, patients with infections, complications, errors in diagnosis and treatment, patients currently hospitalized with unsolved clinical problems, proper utilization of Hospital facilities and services, and other significant patient care matters. Minutes shall be kept of all meetings. The Department Chairperson may schedule additional meetings at his or her discretion.

### **D. Reports**

Each Department shall submit a report at the monthly meeting of the Medical Executive Committee summarizing its review activity.

### **E. Voting**

Only Active and Provisional members of the applicable Department may vote on Departmental matters.

## **13.06 DEPARTMENT CHAIRPERSON**

### **A. Appointment of Department Chairperson**

Each Department shall be organized as part of the Medical Staff and shall have a Chairperson responsible for the functioning of the Department who shall have general supervision of the clinical work within his or her Department. Departmental chairpersons shall be appointed by the

Cook County Health and Hospitals System Board upon recommendation of the CCHHS Chief Executive Officer. The recommendation of the CCHHS Chief Executive Officer shall be based upon the recommendation of the Chief Operating Officer which recommendation shall be made after consultation with the ~~Chief Medical Officer~~Medical Director and the Medical Executive Committee

### **B. Qualifications of Department Chairperson**

In addition to the criteria previous mentioned in these Bylaws under Article 4, Section, 4.02 “Eligibility for Membership: Qualifications and Standards”, each Department Chairperson is required to be certified by the appropriate Board in his/her specialty or comparable competency which has been affirmatively established by the credentialing process.

### **C. Responsibilities of Department Chairperson**

The responsibilities of the Department Chairperson shall include, but not be limited to:

- (1) Oversight of all clinical activities conducted within the Department;
- (2) Oversight or performance of all administrative responsibilities of the Department, unless otherwise provided for by the hospital;
- (3) Integration of the Department into the overall operation and primary functions of the Hospital;
- (4) Coordination and integration of interDepartmental and intraDepartmental services;
- (5) Development and implementation of policies and procedures to guide and support the provision of care, treatment and services;
- (6) Recommendation for a sufficient number of qualified and competent Departmental personnel to provide care, treatment, and services to Hospital Administration;
- (7) Continuous surveillance and evaluation of the professional performance (both FPPE and OPPE) of all individuals who have delineated clinical privileges in the Department, in conjunction with the Medical Staff's Quality Assessment and Improvement Committee;
- (8) Recommendation of criteria for clinical privileges that are relevant to the care provided in the Department for the Medical Staff appointment and reappointment process;
- (9) Recommendation of clinical privileges for each member of the Department pursuant to the appointment and reappointment process set forth in Article 4, Medical Membership and Privileges, of these Bylaws;
- (10) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or Hospital;
- (11) Determination of the qualifications and competence of Department or service personnel who are not Licensed Independent Practitioners and who provide patient care, treatment and services in the department or at the Hospital;
- (12) Oversight and maintenance of programs relating to the continuous assessment and improvement of the quality of care, treatment, and services provided, and reporting relative thereto, as required by the Quality Assessment and Improvement Committee;
- (13) Maintenance of quality control programs;
- (14) Enforcement of the Hospital's Bylaws, policies and procedures, the Medical Staff's Bylaws, rules and regulations, and the rules and regulations of the Department;

- (15) Implementation of recommendations of the Medical Executive Committee within the Department;
- (16) Orientation and continuing education of all Members in the Department of service;
- (17) Evaluation and recommendation of the Department's space and other resource requirements;
- (18) Oversight of the teaching, education and research programs in his or her Department except where otherwise provided for by the Accreditation Council on Graduate Medical Education;
- (19) Assisting in the preparation of reports relating to the Department including, but not limited to, the annual report, as may be required by the Medical Executive Committee, the Chief Operating Officer, the CCHHS Chief Executive Officer or the Board of Directors; and
- (20) Such other duties commensurate with the office as may from time to time be reasonably requested by the President of the Medical Executive Committee, the ~~Chief Medical Officer~~Medical Director, the Chief Operating Officer, the CCHHS Chief Executive Officer or the Cook County Health and Hospitals System Board.

#### **D. Removal of Department Chairperson**

After consultation with the ~~Chief Medical Officer~~Medical Director, Medical Executive Committee and the Chief Operating Officer, the CCHHS Chief Executive Officer of the Cook County Health and Hospitals System may remove a Department Chairperson from his or her appointed position as Department Chairperson. The CCHHS Chief Executive Officer shall provide the Department Chairperson with written notice, which shall:

- (1) State the action which has been recommended or proposed against him or her;
- (2) Include a statement of the reasons for the recommendation or action;
- (3) Inform the Department Chairperson of his or her right to request a hearing before the CCHHS Chief Executive Officer within thirty (30) days after the date of the notice;
- (4) Inform the Department Chairperson that upon receipt of his or her hearing request, he or she shall be notified of the date, time and place of the hearing, which date shall be not less than fourteen (14) days after the date of the notice and, in any event, shall commence within thirty (30) days of the receipt of the hearing request unless the parties agree otherwise; and
- (5) State that failure to request a hearing within the time stated and in a proper manner constitutes a waiver of his right to a hearing and to a review on the matter.

Notice shall be as provided in Section 19.04 B Special Notice of these Bylaws.

If the Department Chairperson waives his or her right to a hearing, the decision to remove him or her shall be final and shall be implemented by the CCHHS Chief Executive Officer. If the Department Chairperson exercises his or her right to a hearing, he or she shall appear before the CCHHS Chief Executive Officer. At this appearance, the Department Chairperson shall be informed of the reasons for the intended removal and shall be invited to discuss, explain or refute them.

If, at the conclusion of the hearing the CCHHS Chief Executive Officer determines that the Department Chairperson should not be removed from his or her appointed position as Department

Chairperson, such decision shall be final and the matter shall be concluded.

If at the conclusion of the hearing the CCHHS Chief Executive Officer determines that the Department Chairperson should be removed from his or her appointed position as Department Chairperson, the CCHHS Chief Executive Officer of the Cook County Health and Hospitals System shall submit a report to the Joint Conference Committee which shall specifically refer to the conduct or activity which is the basis for the decision to remove the Department Chairperson. The Department Chairperson shall be given a copy of this report contemporaneous to its issuance to the Joint Conference Committee.

Within ten (10) days after receipt of the report of the CCHHS Chief Executive Officer, the Department Chairperson may submit to the Joint Conference Committee a written statement in opposition to the report. If no written statement is tendered within the time allotted, the decision to remove the Department Chairperson from his or her appointed position shall be final. If a written statement is tendered within the time allotted, the Joint Conference Committee shall consider the report of the CCHHS Chief Executive Officer and the Department Chairperson's written statement in opposition thereto, and shall forward its recommendation and reasons therefore to the Board for final action.

Removal of a Department Chairperson from his or her appointed position as Department Chairperson shall not affect the Member's Medical Staff membership or clinical privileges and shall not constitute a corrective action as provided in Article 6, Corrective Action, of these Bylaws.

### **13.07**                    **DIVISIONS**

Departments may be divided into divisions which, generally, shall be composed of professionally recognized specialty or subspecialty fields within the general field of the Department. Divisions may be designated when a significant number of Members actively engages primarily in that specialty or subspecialty area and are available to participate in accomplishing functions assigned to the division by the Department. Members assigned to divisions shall also be members of the Department within which the division exists. The above criteria and such others as may be deemed appropriate shall be used by the applicable Department and the Medical Executive Committee in recommending whether to establish or abolish divisions. Such recommendations shall be transmitted to the Chief Operating Officer for his or her recommendation. All recommendations shall be forwarded to the CCHHS Chief Executive Officer for consideration. If the CCHHS Chief Executive Officer recommends any action, such recommendation shall be forwarded to the Cook County Health and Hospitals System Board for final approval. The above notwithstanding, the Cook County Health and Hospitals System Board may, on its own initiative, propose the establishment or abolishment of a division which proposal shall be forwarded to the Chief Operating Officer who shall refer the matter to the appropriate Department and the Medical Executive Committee for consideration and recommendation in accordance with the procedures set forth in this Section.

### **13.08**                    **DIVISION CHAIR**

#### **A. Appointment of Division Chair**

Each division shall have a division=chair who shall be appointed by the Cook County Health

and Hospitals System Board upon recommendation of the CCHHS Chief Executive Officer. The recommendation of the CCHHS Chief Executive Officer shall be based upon the recommendation of the Chief Operating Officer which recommendation shall be made after consultation with the ~~Chief Medical Officer~~Medical Director and the Medical Executive Committee

### **B. Qualifications of Division Chairperson**

In addition to the criteria previous mentioned in these bylaws under Article 4, Section, 4.02 “Eligibility for Membership: Qualifications and Standards”, each Division Chairperson is required to be certified by the appropriate Board in his/her specialty or comparable competency which has been affirmatively established by the credentialing process.

### **C. Function of Division Chair**

The Division chair is responsible for the functioning of the division and shall have general supervision of the clinical work within the division. The Division chair shall report to the Chairperson of the Department within which the division exists.

### **D. Removal of Division-Chair**

After consultation with the ~~Chief Medical Officer~~Medical Director, Medical Executive Committee and the Chief Operating Officer, the CCHHS Chief Executive Officer may remove a Division chair from his or her appointed position as Division chair. The CCHHS Chief Executive Officer shall provide the Division chair with written notice, which shall:

- (1) State the action which has been recommended or proposed against him or her;
- (2) Include a statement of the reasons for the recommendation or action;
- (3) Inform the Division chair of his or her right to request a hearing before the CCHHS Chief Executive Officer within thirty (30) days after the date of the notice;
- (4) Inform the Division chair that upon receipt of his or her hearing request, he or she shall be notified of the date, time and place of the hearing, which date shall be not less than fourteen (14) days after the date of the notice and, in any event, shall commence within thirty (30) days of the receipt of the hearing request unless the parties agree otherwise; and
- (5) State that failure to request a hearing within the time stated and in a proper manner constitutes a waiver of his right to a hearing and to a review on the matter.

Notice shall be as provided in Section 19.04 B Special Notice of these Bylaws.

If the Division chair waives his or her right to a hearing, the decision to remove him or her shall be final and shall be implemented by the CCHHS Chief Executive Officer. If the Division chair exercises his or her right to a hearing, he shall appear before the CCHHS Chief Executive Officer. At this appearance, the Division chair shall be informed of the reasons for his or her intended removal and shall be invited to discuss, explain or refute them. If, at the conclusion of the hearing, the CCHHS Chief Executive Officer determines that the Division chair should not be removed from his or her appointed position as Division chair, such decision shall be final and the matter shall be concluded.



If, at the conclusion of the hearing, the CCHHS Chief Executive Officer determines that the Division chair should be removed from his or her appointed position as Division chair, the CCHHS Chief Executive Officer shall submit a report to the Joint Conference Committee which shall specifically refer to the conduct or activity which is the basis for the decision to remove the Divisional Director. The Division chair shall be given a copy of this report contemporaneous to its issuance to the Joint Conference Committee.

Within ten (10) days after receipt of the report of the CCHHS Chief Executive Officer, the Division chair may submit to the Joint conference Committee a written statement in opposition to the report. If no written statement is tendered within the time allotted, the decision to remove the Division chair from his appointed position shall be final. If a written statement is tendered within the time allotted, the Joint Conference Committee shall consider the report of the CCHHS Chief Executive Officer and the Division chair's written statement in opposition thereto and shall forward its recommendation and reasons therefore to the Board for final action.

Removal of a Division chair from his or appointed position as Division chair shall not affect the Member's Medical Staff membership or clinical privileges and shall not constitute a corrective action as provided in Article 6, Corrective Action, of these Bylaws.

## **ARTICLE 14: COMMITTEES**

### **14.01 APPOINTMENT TO AND REPORTS OF COMMITTEES**

All committee members and committee chairpersons, except those whose membership or chairship is otherwise stated in these Bylaws, shall be appointed for a two (2) year term by the President of the Medical Staff upon the President's assumption of office. Unless otherwise provided, the President of the Medical Staff, the Chief Operating Officer and the ~~Chief Medical Officer~~Medical Director shall be ex-officio members of all Medical Staff committees. Where committee membership calls for non-medical staff members, the President of the Medical Staff in conjunction with the Chief Operating Officer shall make the appointment unless otherwise specified in these Bylaws. Each member of a committee, with the exception of ex-officio members, shall have one vote. A committee member appointed by the President of the Medical Staff may be removed by the President of the Medical Staff. Vacancies on any Medical Staff committees shall be filled in the same manner as original appointments to such committees are made. The Chairperson of a committee may request that the number of members of a committee be increased by up to an additional one-third of the members provided for in these Bylaws. Any such increase must be approved by the Medical Executive Committee.

All committees, shall report in a timely fashion to the Medical Executive Committee. All committees, with the exception of the Bioethics, Bylaws, Credentials, Joint Conference, Nominating, and Physician Assistance Committees, shall also report to the Quality Assessment and Improvement Committee of the Medical Staff. The Medical Executive Committee shall report to the Joint Conference Committee. The standing committees of the Medical Staff shall be those set forth in this Article of the Bylaws. Medical Staff Committees may be established or abolished upon recommendation of the Medical Executive Committee to the Joint Conference Committee and upon approval by the Cook County Health and Hospitals System Board.

## **14.02 BIOETHICS COMMITTEE**

### **A. Composition**

The Bioethics Committee shall consist of three (3) members of the Medical Staff and at least one representative of each of the following areas: Nursing, Social Work, Clergy, Psychology and the Community. A representative of Hospital Administration and of the Cook County State's Attorney's Office shall be ex-officio members. Members of the Bioethics Committees shall be appointed in consultation with the committee Chairperson.

### **B. Duties**

The duties of the Bioethics Committee shall be:

- (1) To discuss ethical principles and standards relevant to the current practice of medicine;
- (2) To formulate medical ethical policies; and
- (3) To apply medical ethical principles and make recommendations on referred individual or specific cases of hospitalized patients.

### **C. Meetings**

The Bioethics Committee shall meet quarterly and shall maintain a permanent record of its proceedings and actions.

## **14.03 BYLAWS COMMITTEE**

### **A. Composition**

The Bylaws Committee shall consist of at least four (4) members of the Medical Staff.

### **B. Duties**

The Bylaws Committee shall consider such amendments to the Bylaws and Rules and Regulations as may be desirable to advance the quality of patient care in addition to the interest of the Medical Staff and the Hospital. The Committee shall also conduct an annual review of the Bylaws and Rules and Regulations and make any recommendations for appropriate revisions and amendments to the Medical Executive Committee. The Bylaws Committee shall serve as an Advisory Committee to Hospital Administration and the President of the Medical Staff in the interpretation and enforcement of the existing Bylaws and Rules and Regulations.

### **C. Meetings**

The Committee shall meet as deemed necessary but at least annually and shall maintain a permanent record of its proceedings and actions.

#### **14.04 CREDENTIALS COMMITTEE**

##### **A. Composition**

The Credentials Committee shall consist of at least seven (7) members of the Medical Staff, selected on a basis that will ensure representation of the major clinical specialties and the Medical Staff at large. Members of the Credentials Committee shall be appointed by the President of the Medical Staff after consultation with the ~~Chief Medical Officer~~ Medical Director.

##### **B. DUTIES**

The duties of the Credentials Committee shall be:

- (1) To investigate the credentials for all Applicants for membership and clinical privileges and to make recommendations for membership and clinical privileges in compliance with these Bylaws, including requests for clinical privileges by Allied Health Professionals who shall not be members of the Medical Staff;
- (2) To make a written report to the Medical Executive Committee regarding each Applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the Departments in which such Applicants request privileges;
- (3) To investigate any breach of ethics that is reported to it;
- (4) To review, regularly, information available regarding the competency of staff members and Allied Health Professionals, as a result of such reviews, OPPE and FPPE to make recommendations regarding the granting of clinical privileges, reappointments, and the assignment of Members and Allied Healthcare Professionals to the various Departments; and
- (5) To review reports that were referred by the Medical Executive Committee, the Medical Records Committee, the Utilization Review Committee and the President of the Medical Staff.

##### **C. MEETINGS**

This Committee shall meet monthly, minimum 10/yr, and shall maintain a permanent record of its proceedings and actions.

#### **14.05 GRADUATE MEDICAL EDUCATION COMMITTEE**

##### **A. Composition**

Medical Staff members of the committee shall be representatives of each of the Departments that have a house staff/residency program and shall be appointed by the President of the Medical Staff. Further, at least one Chief Resident of any Hospital based and/or affiliated Residency Program will be appointed as a member of the committee.

##### **B. Duties**

1. Communicate with the Medical Executive Committee and Governing Body about the safety and quality of patient care and services by and related to the education and

- supervision of resident physicians.
- 2. Establishment and implementation of policies and procedures related to resident supervision and elevations.
- 3. Establishment and maintenance of an appropriate oversight liaison with Program Directors.
- 4. Review all internal GME office residency program reviews and ACGME letters of accreditation relative to the rotations that the residents do at Provident Hospital of Cook County and assure appropriate plans of correction have been implemented.
- 5. Assure all institutional requirements for RRC reviews are in place.

### **C. Meetings**

The committee shall meet at least quarterly with a report of the proceedings of the meeting forwarded to the Medical Executive Committee.

## **14.06 MEDICAL EXECUTIVE COMMITTEE**

### **A. Composition and Size**

All Members of the OMS shall be eligible to be elected and to serve as a member of the MEC. The Medical Executive Committee shall consist of no more than 25 of the following voting members:

- (1) The officers of the Medical Staff;
- (2) The chairpersons of the Departments and divisions specified in Article 13;
- (3) The Chairperson of the Credentials Committee;
- (4) The Chairperson of the Quality Performance and Improvement Committee;
- (5) Three (3) at-large members of the Medical Staff elected at the annual meeting;
- (6) Other practitioners and individuals as determined by the OMS

In addition to the Chief Operating Officer and the ~~System Chief Executive Officer, System Chief Medical Officer~~Executive Medical Director, Chief Medical OfficerMedical Director, the Chair of the Board's Quality and Patient Safety Committee, the Director of Nursing and the Director of Quality Services shall be ex-officio members of this Committee.

The appointment of other practitioners and/or individuals to the MEC as per (6) above shall require a 2/3 affirmative vote of the OMS on a case by case basis at its regularly scheduled Quarterly Medical Staff meeting.

### **B. Duties**

The duties of the Medical Executive Committee shall be:

- (1) To make recommendations to the Cook County Health and Hospitals System Board, and the Joint Conference Committee for the Board's approval pertaining to:
  - (a) The structure of the Medical Staff;
  - (b) The mechanism used to review credentials and delineate clinical privileges;
  - (c) Recommendations of individuals for Medical Staff membership;

- (d) Recommendations for delineated clinical privileges upon appointment and reappointment and Departmental assignment for each eligible individual;
  - (e) The organization of quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;
  - (f) The mechanism by which membership on the Medical Staff may be terminated; and
  - (g) The mechanism for fair hearing procedures;
- (2) To represent the Medical Staff and to act on its behalf between meetings of the OMS, within the scope of its responsibilities as determined by the OMS and in accordance with these Bylaws;
- (3) To enforce the Rules and Regulations of the Medical Staff and to supervise medical staff committees and Departmental affairs;
  - (4) To coordinate the activities and general policies of the various Departments, as required;
  - (5) To receive and act upon committee reports;
  - (6) To implement policies of the Medical Staff not otherwise the responsibility of the clinical Departments;
  - (7) To take all reasonable steps to ensure professional and ethical conduct of all members of the Medical Staff and to initiate and/or participate in Medical Staff disciplinary or appeals measures as indicated;
  - (8) To serve as a liaison between the Medical Staff and the Chief Operating Officer and the Cook County Health and Hospitals System Board;
  - (9) To recommend action to the Chief Operating Officer on matters of a medical-administrative nature;
  - (10) To make recommendations to the Cook County Health and Hospitals System Board, and the Joint Conference Committee, including recommendations for long-range planning;
  - (11) To account to the Cook County Health and Hospitals System Board on behalf of the Medical Staff for the medical care rendered to patients in the Hospital;
  - (12) To ensure that the Medical Staff is kept apprised of the accreditation process and informed of the accreditation status of the Hospital;
  - (13) To provide for presentation of all programs of all meetings, either directly or indirectly through delegation to a program or other committee;
  - (14) To review and approve the rules and regulations of Departments and Divisions regarding meeting requirements relating to quorum, manner of action and attendance; and
  - (15) To report at each general meeting and to act on behalf of the Medical Staff in between their regular and special meetings.
  - (16) To request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.

The authority of the MEC to act on behalf of the Organized Medical Staff's shall be granted by virtue of the approval of these Bylaws by the OMS. Such authority shall be removed only by the process as outlined in these Bylaws under Article 17, Section 17.02 "Amendments to Bylaws by the Medical Staff" of these Bylaws.

### **C. Meetings**

The Medical Executive Committee shall meet monthly and shall maintain a permanent record of its proceedings and actions. The Chairperson of the Committee shall be the President of the Medical Staff. A special meeting may be called whenever deemed necessary by the Chairperson of the Committee.

## **14.07 INFECTION CONTROL COMMITTEE**

### **A. Composition**

The Infection Control Committee shall consist of at least three (3) representatives of the Medical Staff (including one (1) from the field of clinical laboratory science). The Committee shall also have at least a representative from the Department of Nursing, an infection control manager, a representative from Hospital Administration, and a representative from Central Supply.

### **B. Duties**

- (1) The Infection Control Committee shall be responsible for the surveillance and control of Hospital infection and for promoting preventive and corrective programs designed to minimize infection hazards. The Committee shall be charged with supervision of infection control in all phases of Hospital operations including:
  - (a) All areas, units, or satellite facilities of the hospital where patient services are provided on an ongoing basis;
  - (b) All areas or units of the hospital where specialized patient care, treatment or diagnostic services are provided and which, by the nature of the services provided, require the implementation of infection control principles.
  - (c) All hospital Departments or services that support diagnostic or therapeutic patient care activities and which Departments or services have an impact on infection control.
- (2) The Infection Control Committee shall develop and implement policies and procedures pertaining to at least the following:
  - (a) Responsibilities of each Department or service in Infection Control;
  - (b) Employee health programs, practices and requirements relating to infection control;
  - (c) Surveillance of nosocomial infections;
  - (d) Collection and analysis of infection control data and risk factors and the recommendation of action and studies relating to infection prevention and control.
  - (e) Sterilization by heat, chemicals or otherwise;
  - (f) Isolation;
  - (g) Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; and
  - (h) Disposal of infectious material.
- (3) The Infection Control Committee shall evaluate and review the effects of intervention strategies on the infection rates and shall report on its findings to the Hospital as requested.
- (4) The Infection Control Committee, through its Chairperson, may recommend that a unit or area of the Hospital be closed in the event that there is reasonable cause to believe that conditions in that unit or area pose a risk or hazard to patients or employees. The

Chairperson shall immediately notify the Chief Operating Officer, the ~~Chief Medical Officer~~Medical Director and the Chairperson of the appropriate Department of any such recommendation.

### **C. Meetings**

The Committee shall meet at least quarterly or more frequently as determined by the Committee and shall maintain a permanent record of its proceedings and actions.

## **14.08 JOINT CONFERENCE COMMITTEE**

This Committee shall include representation from the Cook County Health and Hospitals System Board, Hospital Administration and the Medical Staff.

### **A. Composition**

The Joint Conference Committee shall consist of not less than three (3) members of the Cook County Health and Hospitals System Board as appointed by its Chairman; an equal number of representatives of the Medical Staff ~~who shall consist of~~from among the Officers of the Medical Staff and ~~up to two~~the Department Chairperson(s) who shall be appointed by the President of the Medical Staff to serve terms on this Committee which shall be concurrent with the terms of the Officers of the Medical Staff; the ~~CCHHS-System~~ Chief Executive Officer or designee; the ~~System Chief Medical Officer~~Executive Medical Director, the Chief Operating Officer and the ~~Chief Medical Officer~~Medical Director. The ~~eChairship~~ of this Committee shall alternate annually between a Board member, as appointed by the Board Chairman, and the President of the Medical Staff.

### **B. Duties**

This Committee shall be a medical administrative liaison committee and an official point of contact among the Medical Staff, Cook County Health and Hospitals System Board and the Chief Operating Officer. The Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care. The Committee shall also participate in the credentialing process as set forth in these Bylaws and shall receive the reports of the Medical Executive Committee.

### **C. Meetings**

The Committee shall meet quarterly or a minimum of three times a year. The Committee shall maintain a permanent record of its proceedings and actions and transmit written reports of its recommendations to the Cook County Health and Hospitals System Board and the Medical Executive Committee.

## **14.09 HEALTH INFORMATION AND RECORDS COMMITTEE**

### **A. Composition**

The Health Information and Records Committee shall consist of at least three (3)

representatives from the Medical Staff, a representative from the Nursing Department and Ambulatory, and a representative of Hospital Administration appointed by the Chief Operating Officer. The Health Information and Records Administrator shall also be a member of this Committee and shall act as Secretary.

### **B. Duties**

The Committee shall:

- (1) Make recommendations to the Medical Executive Committee for approval of, use of and/or changes to forms or formats of the medical record and abbreviations;
- (2) Advise and recommend policies for medical record maintenance, ensuring that details are recorded in the proper manner and that sufficient data are present to evaluate the care of patients;
- (3) Recommend proper filing, indexing, and storage systems for all patient medical records;
- (4) Develop policies to guide and advise the Health Information and Records Administrator, Medical Staff and Hospital Administration in matters of privileged communications and release of information;
- (5) Review summary information regarding the timely completion of all medical records on an ongoing basis;
- (6) Recommend the format of the medical record, the forms used in the medical record, and the use of computer and storage systems for medical record purposes;
- (7) Review a representative sample of inpatient, outpatient and emergency patient records with the respective chairperson to determine whether such records are being created and maintained in accordance with Hospital requirements including, but not limited to, whether the records contain the patient's diagnosis, test results, therapy, prognosis, plan of care and condition on discharge; and
- (8) Report to the Medical Executive Committee any Member whose records do not meet the standards established by these Bylaws and the Rules and Regulations for purposes of possible corrective action pursuant to these Bylaws.

Written reports shall be maintained for all evaluations performed and actions taken.

### **C. Meetings**

This Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

## **14.10 NOMINATING COMMITTEE**

### **A. Composition**

The Nominating Committee shall consist of three (3) at large members of the Medical Staff elected at the previous annual meeting.

### **B. Duties**

Prior to each Annual Meeting where officers are elected, this Committee shall select and



present a slate of nominees for the offices of President, Vice President, Secretary and Treasurer of the Medical Staff as well as three (3) nominees for three (3) members-at-large who shall, if elected, serve on the Medical Executive Committee. All nominees for officers shall be made by the members at large and shall be members of the Medical Staff, in good standing, of any discipline or specialty.

### **C. Meetings**

This Committee shall meet at least once prior to the applicable annual meeting and on the call of the President of the Medical Staff and shall maintain a permanent record of its proceedings and actions.

## **14.11 PHARMACY AND THERAPEUTICS COMMITTEE**

### **A. Composition**

The Pharmacy and Therapeutics Committee shall consist of at least four (4) representatives from the Medical Staff, a representative from the Nursing Department, a representative from Hospital Administration, and the Director of Pharmacy of the Hospital who shall act as Secretary of the Committee. The Chairperson of the Committee shall be appointed from among the Medical Staff members.

### **B. Duties**

This Committee shall be responsible for the development and surveillance of the drug utilization policies and practices within the Hospital in order to promote appropriate clinical results and assure patient safety. This Committee shall assist in the formation of professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters pertaining to the use of drugs in the Hospital. It shall also perform the following specific functions:

- (1) Develop and/or approve of policies and procedures related to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials;
- (2) Evaluate protocols regarding the use of investigational or experimental drugs;
- (3) Promote educational programs on drugs and drug therapy for the medical and nursing staffs and other appropriate personnel;
- (4) Develop, review and maintain the Hospital's drug formulary;
- (5) Define and review all significant untoward drug reactions;
- (6) Evaluate and recommend changes in drug usage, as necessary, to improve the appropriateness, safety and effectiveness of such use, based upon drug usage reports and medication error or incident reports.

### **C. Meetings**

This Committee shall meet at least quarterly. This Committee shall maintain a permanent record of its proceedings and actions. This Committee shall report significant findings to the Hospital's Quality Assessment and Improvement Committee.

## **14.12                    PHYSICIAN ASSISTANCE COMMITTEE**

### **A. Composition**

The Physician Assistance Committee shall consist of at least four (4) members of the Medical Staff, at least one (1) of whom shall be a psychiatrist and excluding any members of the Medical Executive Committee, any members of the Peer Review Committee and the ~~Chief Medical Officer~~Medical Director.

### **B. Duties**

This Committee shall assist the impaired physician in obtaining help within the institution or elsewhere. This Committee shall also serve as an educational resource for impaired physicians, the Medical Staff and House Staff. When performing its duties, this Committee shall observe strict rules of confidentiality, subject to the need to transmit information for purposes of patient safety or to fulfill legally mandated reporting requirements.

1. Provides assistance to medical staff members who, because of physical, emotional or mental impairment, are in need of assistance and monitoring in order to gain restoration of optimal functioning and to be able to provide active patient care.
2. Shall receive reports and referrals via the Chairperson, the Medical Director or Employee Health, or a member of the committee as stated above or of complaints, allegations, or concerns regarding a LIP's patient care and behavior, in confidentiality.
3. The Chairperson will call a meeting of the committee to evaluate the veracity of the information and determine what actions should be taken.
4. The Physician Assistance Committee shall report to the Medical Executive Committee periodically its activities as needed.

### **C. Meetings**

This Committee shall meet as necessary and on the call of the Committee Chairperson. It shall maintain a permanent record of its proceedings and action.

## **14.13                    QUALITY AND PERFORMANCE IMPROVEMENT COMMITTEE**

### **A. Composition**

The Quality and Performance Improvement Committee shall consist of those persons or members of groups identified in the Hospital's Quality Assessment and Improvement Plan, which shall become a part of the Rules and Regulations when approved by the Medical Staff and the Cook County Health and Hospitals System Board.

## **B. Duties**

The Quality and Performance Improvement Committee shall monitor the patient care and support activities on a hospital-wide basis in order to improve the quality of patient care and reduce morbidity and mortality. Included in the duties of the Committee are the following:

- (1) To direct Hospital Departments, medical services, certain committees and quality assessment personnel to evaluate specific indicators;
- (2) To supervise and control the clinical appraisal mechanisms of this Medical Staff and to promote appropriate standards and accountability in patient care;
- (3) To monitor investigation of identified problems and to ensure that corrective procedures are initiated; and
- (4) To review the Hospital's Quality Assessment and Improvement Plan annually and to oversee its implementation.

Utilization Review is a sub-committee of QPI.

The Utilization Review Committee shall consist of those persons or members of groups identified in the Hospital's Utilization Review Plan.

### **Duties:**

- (1) Assure effective and efficient Utilization of available Hospital facilities and services commensurate with quality patient care and safety;
- (2) Monitor length of stay and occupancy levels;
- (3) Intercede in difficult length of stay problems;
- (4) Work to develop an effective discharge planning process; and,
- (5) Review denial of payment cases

## **C. Meetings**

This Committee shall meet monthly at least 10/year and shall maintain a permanent record of its proceedings and actions.

## **14.14 INSTITUTIONAL REVIEW BOARD COMMITTEE**

The System-Wide Institutional Review Board Committee shall serve as the IRB Committee for Provident Hospital of Cook County medical staff. The Provident Hospital representative(s) will be appointed to the Committee by the President of the Medical Staff.

## **14.15 SURGICAL CASE REVIEW AND BLOOD USAGE COMMITTEE**

### **A. Composition**

This Committee shall consist at least of the Chairpersons of the Departments of Obstetrics and Gynecology, Medicine, Surgery, Anesthesiology, the Chairperson of Pathology, the

Chairperson of the Tumor Committee or their permanent designated representatives. In addition, the President of the Medical Staff shall appoint at least two additional members who shall have specialized training in radiology, oncology or infectious disease.

## **B. Duties**

- (1) This Committee shall be responsible for the review of surgical and other invasive procedures by the clinical Departments and services according to established guidelines, which reviews shall be designed to:
  - (a) Evaluate and improve the appropriateness, quality and effectiveness of such procedures; and
  - (b) Identify significant discrepancies or patterns of discrepancies between the pre-operative and post-operative (including pathologic) diagnoses.
- (2) This Committee shall also be responsible for the review of the distribution, ordering, handling, use or administration of whole blood and blood components according to established guidelines, which reviews shall be designed to:
  - (a) Continuously improve the processes involved in the ordering, distribution, handling, dispensing, administration and monitoring of whole blood and blood components, including the development or approval of policies and procedures;
  - (b) Evaluate the appropriateness of transfusions performed;
  - (c) Evaluate all confirmed transfusion reactions;
  - (d) Review the adequacy of transfusion services to meet the needs of patients.
- (3) Surgical and Blood Review shall be performed using pre-determined clinically valid criteria. Screening mechanisms such as the frequency and degree of risk associated with the various procedures and blood usages shall be considered in identifying cases for review.
- (4) The Committee shall prepare and maintain written reports of conclusions, recommendations and remedial actions. Such reports shall be submitted to the Quality Assessment and Improvement Committee. The Committee shall also communicate documented individual performance problems to the appropriate Department or committee.

## **C. Meetings**

This Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

## **14.16 OPERATING ROOM/POST ANESTHESIA CARE UNIT (PACU) COMMITTEE**

### **A. Composition**

The System PACU Committee shall serve as the OR PACU Committee for Provident Hospital of Cook County. This Committee shall consist of a representative from the following Departments: At least one medical staff from each of the Departments of Anesthesiology, Obstetrics & Gynecology and Surgery. It shall also include the appropriate, Nursing, Nurse Manager from OR/PACU, and Infection Control.

## **B. Duties**

This Committee shall be responsible for the oversight of the operation of the Operating Room, the PACU, and Same Day Surgery.

1. Evaluate such matters as distribution of rooms to services, operating time, conditions and maintenance of and maintenance of the operating rooms and adequacy of personnel.
2. Review and/or develop operational policies relating to areas covered above.
3. Assure compliance with local, state and federal regulation, guidelines and regulatory agencies.

## **C. Meetings**

The Committee shall meet quarterly and shall maintain a permanent record of its proceedings and actions. A written copy of all proceedings and actions shall be made and kept in form apart of a permanent report to the medical executive committee.

## **ARTICLE 15: COMMITTEE, DEPARTMENTAL AND DIVISIONAL MEETINGS**

### **15.01 COMMITTEE MEETINGS**

Committees shall meet regularly as set forth in Article 14 of these Bylaws.

### **15.02 DEPARTMENTAL AND DIVISIONAL MEETINGS**

Departments and divisions shall hold regular meetings to conduct Departmental or divisional business and to review and evaluate the clinical work of Members with privileges in the Department or division in accordance with the requirements established by appropriate accrediting bodies and in conjunction with the Quality Performance and Improvement Committee of the Medical Staff.

### **15.03 SPECIAL MEETINGS**

A special meeting of any committee, Department or division may be called by or at the request of the Chairperson thereof, by the President of the Medical Staff, or by one-third (1/3) of the applicable group's voting members but not less than two (2) members.

### **15.04 NOTICE OF MEETINGS**

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting shall be given to each member of the committee, Department or division not less than five (5) days before the date of such meeting by the person or persons calling the meeting. If delivered

by United States mail, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at his or her address as it appears in the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute waiver of notice of such meeting.

#### **15.05 RULES; DEPARTMENTAL AND DIVISIONAL MEETINGS**

Departments and divisions may establish their own rules regarding quorum, manner of action and attendance requirements for meetings providing such rules are approved by the Medical Executive Committee. If no such rules are established, the provisions of Article 15, Section 15.06, General Rules Regarding Quorum, Manner of Action, Minutes and Attendance Requirements, Subsections (a), (b), (c) and/or (d), of these Bylaws, shall apply.

#### **15.06 GENERAL RULES REGARDING QUORUM, MANNER OF ACTION, MINUTES AND ATTENDANCE REQUIREMENTS**

The following rules shall apply to all committees and to Departments and divisions which have not established different rules in accordance with Article 15, Section 15.05, Rules; Departmental and Divisional Meetings, of these Bylaws.

##### **A. Quorum**

Fifty (50%) percent of the medical staff membership of a Department or fifty (50%) percent of committee members, but not less than two (2) members, shall constitute a quorum for such meeting.

##### **B. Manner of Action**

The action of the majority of the members present with voting privileges at a meeting at which a quorum is present shall be the action of the Department, committee or division. Action may be taken without a meeting by unanimous consent, in writing, setting forth the action so taken and signed by each member entitled to vote.

##### **C. Minutes**

Minutes of each regular and special meeting of the committee, Department or division shall be prepared and shall include a record of the attendance of members and vote taken on each matter.

The minutes shall be signed by the presiding officer and copies forwarded to the Medical Executive Committee. Each committee, department and division shall maintain the permanent file or minutes for each meeting.

##### **D. Attendance Requirement**

Each member of the Medical Staff is expected to attend Departmental and division meetings in accordance with Departmental and division rules. Such rules shall be submitted for review by the Medical Executive Committee or subject to the Medical Executive Committee's approval prior to implementation. Any member of the Medical Staff who is compelled to be absent from a meeting of the Department or division shall submit to the Chairperson in writing the reasons for

such absence requesting that the absence be excused. Failure to meet Departmental attendance requirements may be grounds for corrective action and will be considered with respect to reappointment and advancement.

Medical Staff members are expected to meetings to which they are required or assigned. Unexcused absences of greater than 50% of the scheduled meetings in accordance with the attendance requirements may result in removal from the committee and may give rise to corrective action which may include administrative suspension. The President of Medical Staff shall have the authority to remove from a committee assignment a medical staff member who fails to dedicate the required time and effort to the work of the committee where the interests of the Hospital may be impaired by the committee's failure to fulfill its responsibilities.

#### **15.07 MEDICAL STAFF MEMBERS OF THE ADMINISTRATION**

It is recognized that some members of the Hospital administration, e.g. the [Chief Medical Officer](#)~~Medical Director~~, may submit an application for initial appointment or reappointment pursuant to Article 4, Sections 4.04 and 4.06, Procedure for Appointment and Reappointment. Such Members shall be assigned to a Department according to their training and experience for the purpose of performing clinical, educational and research functions but are not otherwise required to participate in Department, Division or Section activities.

#### **15.08 RIGHTS OF EX-OFFICIO MEMBERS**

Persons serving under these Bylaws as ex-officio members of a committee or Department shall have all rights and privileges of regular members, except they shall not have the right to vote or hold office. Only members having the right to vote shall be counted towards a quorum or for the purpose of meeting committee composition requirements.

### **ARTICLE 16: RULES AND REGULATIONS AND POLICIES**

#### **16.01 ADOPTION OF RULES AND REGULATIONS AND POLICIES**

Subject to Section 16.02, below, the Medical Executive Committee or the OMS shall adopt such Rules and Regulations and Polices as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Cook County Health and Hospitals System Board. These shall relate to the proper conduct of Medical Staff organizational activities and shall establish the level of practice that is to be required for each Member in the Hospital.

#### **16.02 AMENDMENTS TO RULES AND REGULATIONS AND POLICIES**

Such Rules and Regulations shall be a part of these Bylaws.

These Rules and Regulations and MS Policies may be amended or repealed by either the MEC or OMS:

- 1) At any regular meeting of the MEC at which a quorum is present; or
- 2) At any regular meeting of the OMS with proper notice and 2/3 votes of the voting members present.

The OMS may propose amendment(s) to the Rules and Regulations or policies directly to the Board; however, the OMS must first notify MEC regarding such amendments thereto with sufficient time for MEC comments or to allow for the triggering of the conflict management process. If the MEC proposes to adopt a rule or regulation or policy or an amendment thereto, it will first communicate the proposal to the OMS at its next regular meeting.

Such changes shall become effective when approved by the Cook County Health and Hospitals System Board and shall be communicated to the OMS as soon as practicable.

In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulations, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the OMS. In such cases the OMS will be immediately notified by the MEC through its President. The OMS will have the opportunity to retrospectively review and comment on the provisional amendment. If there is no conflict between the MEC and the OMS the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict will be implemented. If necessary, based on the outcome of the conflict resolution process, a revised amendment will be submitted to the Cook County Health and Hospitals System Board for approval.

## **ARTICLE 17: BYLAWS**

### **17.01 AMENDMENTS TO BYLAWS BY MEDICAL STAFF**

Any proposed amendment(s) to these Bylaws may be referred to the Bylaws Committee, for review and discussion. The Bylaws Committee shall transmit its recommendation on the proposed amendment to the Medical Executive Committee within 90 days. The Medical Executive Committee shall review and discuss the proposed amendment(s) and shall distribute the proposed amendments and all recommendations thereon to all Active members of the Medical Staff for review and comment prior to the next Regular Meeting of the Medical Staff or any Special Meeting called for such purpose. To be adopted by the Medical Staff, an amendment shall require the approval of two-thirds (2/3) vote of the members present. Amendments so made shall be directed to the Medical Executive Committee and become effective when approved by the Cook County Health and Hospitals System Board.

These Bylaws may be amended or repealed;

- 1) At any regular meeting of the MEC at which a quorum is present; or
- 2) At any regular meeting of the OMS with proper notice and 2/3 votes of the voting members



present.

The OMS may propose amendment(s) to these Bylaws directly to the Board; however, the OMS must first notify MEC regarding such proposed amendments with sufficient time for MEC comments or to allow for the triggering of the conflict management process. If the MEC proposes an amendment to these Bylaws, such changes will first be communicated to the OMS at its next regular meeting.

Such changes shall become effective when approved by the Cook County Health and Hospitals System Board and shall be communicated to the OMS as soon as practicable.

## **17.02 AMENDMENTS TO BYLAWS BY COOK COUNTY HEALTH AND HOSPITALS SYSTEM BOARD**

These Bylaws may be amended by the Cook County Health and Hospitals System Board at any regular or special meeting of the Board. A copy of any proposed amendment(s) to these Bylaws shall be submitted to each member of the Bylaws Committee and the Medical Executive Committee at least thirty (30) days in advance of the meeting at which the Cook County Health and Hospitals System Board considers the proposed amendments. Responses from the Bylaws Committee and from the Medical Executive Committee shall be submitted directly to the Cook County Health and Hospitals System Board with a copy to the other committee prior to the Board meeting at which this matter will be considered.

If the Organized Medical Staff is in disagreement with the proposed amendment(s), the matter shall be referred to the Joint Conference Committee for further study and recommendation before final action is taken by the Cook County Health and Hospitals System Board. The Joint Conference Committee must make its recommendation to the Cook County Health and Hospitals System Board within 60 days of receipt of the proposed amendments.

Such amendment(s) to these Bylaws adopted by the Cook County Health and Hospitals System Board shall become effective upon approval of the OMS or Medical Executive Committee.

## **17.03 AMENDMENT OF BYLAWS, GENERALLY**

Neither the organized medical staff, the MEC nor the governing body may unilaterally amend the Bylaws. The notification and time lines set forth in this Article may be waived by the Medical Executive Committee or the OMS in the event of an urgent need for amendments to the Bylaws; for example, in order to meet legal, regulatory or accreditation standards. In any such situation, the MEC shall immediately notify the OMS.

## **ARTICLE 18: NON-MEMBER PRACTITIONERS**

### **18.01 LICENSED INDEPENDENT PRACTITIONER**

#### **A. Clinical Privileges**

Licensed Independent Practitioners (LIP) shall make application for Clinical Privileges on forms prescribed by the Credentials Committee. The Chair of the Department to which the LIP is to be assigned shall submit LIP's qualifications and request for privileges along with his or her written recommendation to the Credentials Committee. The Credentials Committee shall review the LIP's qualifications, shall obtain any necessary verifications through the Credentialing Verification Office, and shall request from the LIP any additional information, which may include a request that the LIP appear before the Credentials Committee. The Credentials Committee shall forward its recommendation on the Clinical Privileges to be granted to the LIP to the Medical Executive Committee for its review recommendation. The Medical Executive Committee shall review the recommendation of the Credentials Committee and shall transmit its recommendation directly to the Board which shall approve or disapprove any requested Clinical Privileges for a period not to exceed two years. Renewal of Clinical Privileges shall be accomplished through a similar procedure.

#### **B. Corrective Action**

An LIP is subject to the same procedures set forth in Article VII, Corrective Action, and VIII, Hearing and Appeal Procedure, except that such corrective action is limited to the modification, probation, suspension or termination of his or her clinical privileges. The results of the corrective action process are not a limitation on the Hospital's authority to take any employment or contractual action with respect to the LIP.

### **18.02 MID-LEVEL PRACTITIONERS**

#### **A. Collaborative Clinical Privileges**

Mid-Level Practitioners (MLP) shall make application for Collaborative Clinical Privileges on forms prescribed by the Credentials Committee.

#### **B. Corrective Action**

The Credentials Committee shall receive all reports with respect to MLP's which are made pursuant to Article VII, Section 1, Grounds, and shall immediately refer such reports to the System Mid-Level Practitioner Committee, which shall investigate the matter, shall conduct a hearing if appropriate in accordance with System Policy, and take appropriate action. The System Mid-Level Practitioner Committee shall prompt report its decision to the Credentials Committee, which shall review the decision and determine if any additional action is required to the Collaborative Clinical Privileges of the MLP.

### **18.03 SUSPENSION OF MLP COLLABORATIVE CLINICAL PRIVILEGES OR LIP CLINICAL PRIVILEGES**

In addition to any other persons who may be authorized to do so, the Chief Operating Officer, the ~~Chief Medical Officer~~[Medical Director](#) and the Credentials Committee shall have the

authority to immediately suspend or otherwise restrict the Collaborative Clinical Privileges or Clinical Privileges of any Non-Member Practitioner pending final action following a report pursuant to Article VII, Section 1, Grounds.

## **ARTICLE 19: MISCELLANEOUS PROVISIONS**

### **19.01 EFFECT OF HEADINGS AND TABLE OF CONTENTS**

The Article and Section headings herein and the Table of Contents are for convenience only and shall not affect the construction hereof.

### **19.02 SEVERABILITY CLAUSE**

In case any provision in these Bylaws shall be held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall in no way be affected or impaired thereby.

### **19.03 COUNTING OF DAYS**

In any instance in which the counting of days is required in these Bylaws except where it is explicitly noted, shall be implied to be calendar days. The giving of notice or for any other purpose, the day of the event shall not count, but the day upon which the notice is required to be given shall count. In any case where the date on which some action is to be taken, notice is to be given or period is to expire occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such notice given or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday or Friday which is not a holiday. For the purposes of this Section, the term "holiday" shall mean such days as are officially recognized as holidays by the County of Cook, Illinois.

### **19.04 NOTICES**

(a) General Notice. All notices, requests, demands, reports, written statements and other communications required or permitted to be given to any Applicant or Member in these Bylaws shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States mail, postpaid, to the address of the Applicant or Member on his or her application or to his or her last known address according to the books and records of the Hospital except when special notice as provided in paragraph (b) of this Section is required under these Bylaws.

(b) Special Notice. Notice shall be deemed given pursuant to this paragraph (b) if it is deposited in the United States Mail, postage prepaid, by certified or registered mail, to the address of the Applicant or Member on his or her application or to his or her last known address according to the books and records of the Hospital. When Special Notice is provided pursuant to this Section, Notice may, additionally, be sent by regular mail. If notice is sent by both certified and regular mail and the Member fails to accept the certified mail promptly, there shall be a rebuttable presumption that the Member has received notice in satisfaction of the requirements of this paragraph (b) of Section 18.04.

(C) Maintenance of Current Information. All Members shall be obligated to maintain on file

with the ~~Chief Medical Officer~~[Medical Director](#) their current residence address and to notify the ~~Chief Medical Officer~~[Medical Director](#) immediately in writing of any changes thereto.

#### **19.05 GENDER NEUTRALITY**

Wherever the singular is used herein, the plural shall be included.

#### **19.06 CHECKS**

All checks, drafts, or other orders for payment of money from the Medical Staff funds shall be signed by the Medical Staff Treasurer and counter-signed by the President or Vice President of the Medical Staff.

#### **19.07 DEPOSITS**

All funds of the Medical Staff shall be deposited from time to time to the credit of the Medical Staff in such banks, trust companies or other depositories as the Medical Executive Committee may select.

#### **19.08 DUES**

The Medical staff will set the medical staff dues, fees & assessments from time to time after a discussion at a quarterly medical staff meeting. The payments will be made payable to the Provident Hospital of Cook County Medical Staff. The Medical Executive Committee may provide, by resolution, for the manner and time of payment of dues and assessments and may impose suitable penalties for default in payment thereof.

Approved by:	Medical Executive Committee	July 2, 2013
Approved by:	Organized Medical Staff	July 23, 2013
Approved by:	Cook County Health & Hospitals System Board (QPS)	July